SACRED HEART HOSPITAL CLOSURE

Y 4. EN 2/3: 103-128

Sacred Heart Hospital Closure, Seri...

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

JULY 11, 1994

Serial No. 103–128

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U.S. GOVERNMENT PRINTING OFFICE
83-466CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-045964-8

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SACRED HEART HOSPITAL CLOSURE

MONDAY, JULY 11, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
West Norton Township, PA.

The subcommittee met, pursuant to notice, at 11 a.m., in the Norristown Area High School, 1900 Eagle Drive, West Norton Township, Pa., Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. I want to welcome you to this hearing of the Subcommittee on Health and the Environment. Today's hearing comes at a very critical time. We are on the verge of an historic vote in the House of Representatives on reforming the health care system in America, a system in which too many people are uninsured and health care costs are too high.

We have come to Norristown today at the request of Congresswoman Marjorie Margolies-Mezvinsky to see first hand the consequences of a health care system in crisis. Just a few weeks ago, the Sacred Heart Hospital—a provider of health care to this community since 1936—abruptly closed—virtually stranding 97 patients and eliminating over 850 jobs. It is obvious to all that the closure of this institution has had a profound effect not just on patients, employees and their families, but on the community as a whole.

Of course, the question all of us must ask is why did this happen? I hope that today's hearing will help us answer this question and provide important lessons about how to avoid such an occurrence in the future.

Our hearing brings together a number of individuals who have been affected by the closure of Sacred Heart. Some are here to tell us about their own experiences and how they are coping since their jobs were abolished. Others who represent the financial community and the hospital have been invited to share with us their views of what went wrong and what lessons can be learned.

I am particularly interested in learning whether the lack of insurance coverage by some patients of the hospital contributed to its demise. As you know, currently about 11 percent—or more than a million Pennsylvanians—are uninsured.

I am concerned that the closure of this facility has swelled the ranks of the uninsured in the State, and for those employees and their families who have lost their benefits, I want to know what steps are being taken to address their needs.

I want to make it clear that we are here to learn. This is a congressional hearing, not an investigation. We are here to provide a

forum at which representatives of Sacred Heart Hospital and the community can discuss these unfortunate circumstances and offer recommendations on how best to move forward.

Before calling on our first panel of witnesses, I want to recognize my distinguished colleague and a member of the Energy and Commerce Committee who is the Representative of this district in the House.

Congresswoman Marjorie Margolies-Mezvinsky is here and I am here at her request so that we can prepare a record for not just those in the community, but for those of us in the Congress concerned about health care policy. She has been closely involved with the efforts to help those workers who have lost their jobs when the hospital closed, and I want to thank Marjorie Margolies-Mezvinskky for urging this hearing and inviting me to her district and call upon her for an opening statement.

Ms. MARGOLIES-MEZVINSKY. Thank you, Mr. Chairman.

First let me thank Norristown High School for allowing us to use their facilities. The administration at Norristown High School has always been responsive to my office whenever we needed them, whenever I have called, and I am personally grateful for that.

I want to also thank the employees of Sacred Heart Hospital. Your devotion to Sacred Heart and your professionalism is, in a large part, the reason we are here today.

I would also like to thank Representative Waxman, who you have just heard from. He is chairman of the House Subcommittee on Health and the Environment. Mr. Waxman has been a tireless advocate for health care and health care reform and the issues surrounding it and he is weighing in prominently now in the minds of the people of the United States, policymakers in Washington, DC. with regard to health care reform.

As health care reform issues are weighing prominently on the minds of policymakers in Washington, DC., the struggles that are occurring in the health care industry are most telling and they are most telling in every congressional district in the country. That is the reason we are here today.

The closure of Sacred Heart Hospital in Norristown is but the latest chapter in the shifting health care reform. It is a shifting health care reform story that we all must follow. It is a story of hospitals downsizing their facilities, streamlining their staffs to provide more outpatient services, and subacute level care.

It is a story of corporate boards and administrators attempting to react swiftly to the volatile marketplace. It is also a story of success and a story of failure.

Without a doubt, our health care system is changing. Whether or not these changes are market driven or the result of health care reform, when systems change, people are forced to change, too.

Montgomery County has witnessed first hand the consequences of such changes. We have lost a hospital that provided first-rate care to this community for almost 60 years.

Sacred Heart was more than just bricks and mortar for many families whose babies were born there, whose children got their stitches there and whose loved ones were cared for there. The employees, the patients and the community were devastated when the hospital decided to close its doors and to close its doors overnight.

From this tragedy, it is important for us in Congress to learn to understand the far reaching consequences of health care reform. Such reforms are not just about saving money. It is not just about who is and who isn't covered or if covered, whether it will be the Republicans or the Democrats who get their plan through Congress.

Health care reform, as we know it, now is inevitably about employees who lose their jobs; it is about patients who are transferred from hospital to hospital. It is about communities that are struggling to maintain sufficient health care services for all.

Health care reform, therefore, places greater responsibility on the corporate boards and administrators, a greater duty to remain sensitive to the needs of their employees, to the needs of their patients, to the needs of their community during these volatile times.

Today's hearing is, in fact, not about placing blame. It is not about reviewing all of the decisions or lack of decisions taken by the boards and the administrators of Sacred Heart Hospital. We shall leave a more complete review of those actions to another forum on another day.

Today we seek to begin to answer the question, what is the responsibility of a hospital's corporate boards and administrators towards its patients, towards its employees, and towards its community when it faces imminent danger or closure.

This hearing is the beginning of an effort to develop guidelines for hospital administrators and corporate boards to follow during times of financial turmoil and that is the reason why Representative Waxman is here.

Through this, all who are potentially affected by such decisions can be assured that orderly, timely and sensitive solutions will be implemented in the future.

Thank you very much.

Thank you, Mr. Waxman.

Mr. WAXMAN. Thank you very much for your statement.

Our first panel of witnesses this morning includes several individuals who have been associated with Sacred Heart Hospital as employees and health professionals, and I would like to call them forward.

Ms. Tina McClatchy is a registered nurse and until the closure of the hospital was the Clinical coordinator of Ambulatory Surgical Services. Ms. Dot Watson served as a staff nurse at the hospital. Ms. Carolyn Novia was a unit clerk at the hospital, and Dr. Frank Bonner was a member of the hospital's medical staff.

Thank you for being here. Your prepared statements in writing will be placed in the record in full. What we would like to ask each of you to do is to limit the oral presentation that you give to around 5 minutes so that we will have an opportunity for questions and answers and be able to hear from the witnesses that are scheduled as well.

We very much appreciate your being here. What you say to us and how you respond to the questions will help us better understand what has happened and what we need to know for the future.

Ms. McClatchy, why don't we start with you. I will keep a timer, so when you hear the bell, your 5 minutes is up. We would like to ask you to wrap up the oral presentation.

STATEMENTS OF TINA McCLATCHY, FORMER CLINICAL COORDINATOR, AMBULATORY SURGICAL SERVICES; CAROLYN NOVIA, FORMER UNIT CLERK; DOROTHY WATSON, FORMER STAFF NURSE; AND FRANCIS BONNER, JR., DIRECTOR, DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION, ALL OF SACRED HEART HOSPITAL

Ms. MCCLATCHY. Thank you, Mr. Chairman.

Thirty-two years ago, I entered Sacred Heart Hospital School of Practical Nursing. I spent most of my career working at Sacred Heart Hospital. Times away were related to significant changes in my personal agenda: I moved to Florida where I obtained my R.N., and marriage to a widower with six children.

I was acknowledged as an "agent of change" working as critical care staff nurse, coordinating supervisor, diagnostic cardiology, nursing supervisor, clinical coordinator, A.M. Surgical program, and coordinator of ambulatory surgical services.

I believed that each position could enhance the services Sacred Heart Hospital provided to the community. In fact, I believed it so desperately that I convinced others to believe in what I was doing.

Like most employees, I invested my energy and myself. It was always patients first. I participated wholeheartedly to make Sacred Heart Hospital the best it could be.

On Tuesday, May 17, 1994, the CEO informed the department heads of the decision to close the hospital the next day, Wednesday, May 18th. As instructed, I returned to my unit and began calling my staff, then the surgeons and then the patients, attempting to explain what I myself couldn't understand or believe. I just said the words.

It was all very painful, telling patients and physicians not to come for the scheduled surgery for tomorrow; "Sacred Heart Hospital is closing its doors forever." Some yelled. Some cried. Some expressed sadness, but most just couldn't believe it.

I am unable to enlighten you as to the numbing disbelief that overwhelmed us all, patients, staff and physicians.

My hope is that today's inquiry will prevent this nightmare from ever happening again. Over and over people asked what happened? I do not know. However, I can share my feelings.

About 18 months ago, a cancer was revealed—at least that is when the obvious symptoms began to rear their ugly heads.

Parts of the body were removed—person by person—hoping to stop the progression of the disease. Spurts of hopeful news were released and we found solace with this will not happen again, but it did.

Supplies were running out; "on back order." Whispers told us we were on credit hold. Then suddenly, an order would arrive and we would count it as another sign of "being healed" again.

As a manager, I offered support and encouragement; don't let the rumors ruin us. Work smart. I told my staff this and they continued with optimal quality patient care. Patients survey results praised our efforts.

Another sign of hope was assumed as I listened to the volunteers being told at their Spring 1994 reception that: The joint venture is progressing and the administration and board look forward to a new entity as a genuine effort to improve health care services in our community.

I should have recognized this as the final rally just before the end, but instead I still had hope.

As we so often witness in health care, the family was denying the writing on the wall; that vulnerability of a terminal condition.

On Wednesday, May 18th, death came, but this wasn't the death we expected. This wasn't what we were told.

Rather this was a traumatic, abrupt and irreversible event. There was no time to plan. No time to think. No time to grieve. Once again, we just had to care for patients, and we did.

Who took care of me? I have no job. I have no health insurance. I lost vacation, holiday time and pay.

I collect $329 a week in unemployment compensation. I owe payments I can't meet. What happens to my perfect credit history I worked honestly and earnestly to maintain? Who cares?

I am a mature professional who has spent 32 years of my life taking care of others. I did keep my end of the bargain. Then I got dropped on my head, and I am bleeding, and I am asking you, who cares?

Mr. WAXMAN. Thank you very much, Ms. McClatchy. Let me request of the audience that you not applaud or show any kinds of approval or disapproval of the testimony of witnesses, I think, in order for us to have people feel comfortable to say what they have to stay and get it on the record.

Carolyn Novia?

STATEMENT OF CAROLYN NOVIA

Ms. NOVIA. Thank you, Mr. Chairman.

Hello and good morning. I am Carolyn Novia.

I was an employee at Sacred Heart for the past 16 years. I started working as a full-time unit clerk in 1978 with college loans to pay. This job was a godsend.

Although I did not anticipate staying at Sacred Heart for more than 5 years, friendships were made and it became a second home.

It is not easy to describe the bond that Sacred Heart employees have with each other. We touched the lives of so many people by doing what we did best, caring; caring about each other and those we served. I think that is why when rumors started that the hospital might close, many employees looked to the administration for answers.

The administration held meetings and we were told that a possible merger was close at hand. Many of us chose to be optimistic and thought it inconceivable that we would close on Tuesday, May 17th.

I worked the 7 to 3:30 shift. Later that evening, I turned the TV on, only to find that my co-workers and I were now unemployed. I then called the hospital to see if I was needed the next day, although it was my scheduled day off.

My supervisor said they would appreciate as much help as possible. That was my notification; a half day's notice.

I think my memories of Sacred Heart have kept me going through all this; the memory of meeting my future husband, the births of my three children and the friendships I made, although it is with incredible sadness.

I am still unemployed. Being employed for 16 years, it was very difficult for me to collect unemployment and reenter the job market. I had gone to the rapid response meeting held here on May 20th. It made me feel I had options for my future.

I also attended the job fair sponsored by the Delaware Valley Council King of Prussia Chamber of Commerce. I filled out applications only to be informed that the position I held at Sacred Heart was not available at this time at other area hospitals.

I feel, as I assure you many former employees do, that Sacred Heart's administration could have given us more than a half day's notice. After all, we gave our heart and soul to that hospital. I think we deserve a little more than we received.

Thank you.

Mr. WAXMAN. Thank you very much for your testimony, Ms. Novia.

Ms. Watson?

STATEMENT OF DOROTHY WATSON

Ms. WATSON. Good morning.

My name is Dorothy Watson. I was employed at Sacred Heart Hospital for 37½ years as a staff nurse, head nurse, and nurse manager of the nursery.

Not only was Sacred Heart a place of employment, but also my family hospital for health care. All my six children and nine grandchildren were born at Sacred Heart Hospital.

I have been very loyal to the hospital. As far as I was concerned, it was a standard for excellent care in the community. I would encourage all my friends and acquaintances to use Sacred Heart Hospital for their health care needs. None were ever disappointed.

Sacred Heart Hospital was like an extended family with support received from co-workers and administration. I attended many social functions, both unit and hospital-based, formed lifelong friendships and developed a feeling of belonging.

I knew of financial problems for many years, but was a little reassured by administration that the hospital would not close. There are many signs that the hospital would not close, including meetings to assure us, hiring of new and experienced employees who needed intensive orientations, even up to the last few weeks before closing and the approval of purchasing bassinets within the last month of closure.

I was in a state of shock and disbelief when the closure finally occurred May 18. I could not believe it was happening. My notification came from a coworker and the news media on the evening of May 17th. Formal notification was received in a memorandum on the day of closure. I was unable to read it fully until I arrived home from work that day.

The memorandum included a brief description of the disposition of our benefits, unemployment compensation and a notification of an employer-employee assistance session. I attended this meeting on May 19. Many questions were answered, but many were left un-

answered. Some incorrect information was given at this time. My future was in doubt. I knew I faced many changes in my life. My position of over 37 years was terminated in 1 day.

Obtaining a staff nurse position at my age is very difficult and if I would obtain one, it would mean starting all over again. My carefully laid plans for retirement were destroyed. I had planned on working 4½ more years until the age of 65 to increase savings and my tax shelter annuity.

I was depending on my pension to meet my retirement goals. We were notified that the pension plan would be discontinued. Even at this time, I do not know what this will mean to me.

I am counting on ERISA regulations to protect pension benefits. Vacation plans had to be altered. We would not be receiving our accrued vacation and holiday pay. My last payroll deduction into my tax-sheltered annuity is in doubt. Dental benefits were not paid since February. I received extensive dental care during the time I unknowingly was without coverage.

I don't know what is in store for me as far as employment, pension, reimbursement for accrued vacation and holiday pay, and placement of a payroll deduction in my tax shelter annuity. I feel all these things have shown a lack of respect to a long-term loyal employee.

STATEMENT OF FRANCIS BONNER, JR

Mr. BONNER. Good morning.

I am a physician with a specialty in physical medicine and rehabilitation. Until its closing on May 18, 1994, I served as Sacred Heart Hospital's director of the Department of Physical Medicine and Rehabilitation.

I do appreciate the opportunity to be here today so that I can explain why I believe Sacred Heart Hospital's closure occurred. My remarks throughout this presentation will focus on what I know best, and that is from the perspective of rehabilitation services.

Before I describe why I believe the hospital closed, allow me to briefly try to convey to you the effect of the hospital's closure on my patients, on my resident physicians in training, the hospital's staff, physicians, and the Norristown community.

First, the hospital closure greatly affects rehabilitation patients from our region that will now be required to travel another 10 miles to the nearest full-service rehabilitation hospital. Contact with family members, who are so instrumental to a rehabilitation patient's recovery, will be greatly limited by a round trip of over 20 miles. When a rehabilitation patient's condition is associated with an acute injury or illness, continuity with their family physician will be difficult, if not impossible.

Second, our rehabilitation residents in training could have also been significantly affected by this closure. We train 15 residents in rehabilitation medicine, young doctors who are counting on us for medical training, a training that involves many years of highly specialized and very costly education.

A set-back could have left these persons professionally and financially at great risk. We are lucky that the graduate hospital assumed full responsibility for these physicians in training and their training program can continue without diminution of quality.

Third, the hospital employed approximately 850 persons. Approximately 150 of them were associated with the hospital's rehabilitation services. These persons counted on us for their family's economic well-being, in particular those who were single parents or sole wage earners in their families.

Fourth, physicians who specialize in rehabilitation medicine and our community as a whole will be affected by this closure. Specifically, the physicians will have to travel a great distance to see these patients. This will eventually erode our community's ability to hold on to these patients. A broad array of services will flow out of our immediate area, leaving the Norristown community with significant gaps in the continuum of care.

Allow me to turn to reasons why I believe the hospital closed. In assessing these reasons, it is important to examine the health care environment locally in Norristown and also the trend that is happening in our Nation.

On a local level, competition between and among 34 general medical hospitals in Norristown has been fierce. What has often been referred to as "in the interest of our community" might more accurately be described as "institutional self-interest."

Not only did the Norristown hospitals compete amongst each other, they also face stiff competition from large Philadelphia academic medical centers. Norristown is only 40 minutes from Philadelphia, one of the world's most sophisticated medical marketplaces.

In recent years, we have witnessed movement by these centers into suburban communities in efforts described as "outreach", but in reality, reflect their need to capture market share to ensure their continued existence.

Examining the national health care environment reveals several trends that had dire consequences for Sacred Heart Hospital and Rehabilitation Center. Many of these trends involved decreased utilization of acute hospital services. The trends that I believe had the greatest effect on the hospital's closure follow:

First, advances in medical science and technology have resulted in shortened hospital stays. This combined with a rapid growth of ambulatory care for services previously performed only on an inpatient basis has resulted in fewer acute care beds being used throughout the country.

Second, enlightened legislation, such as those that require the use of seat belts, helmet laws, new food labeling requirements, and hopefully strict regulation of the tobacco industry, will lessen our need for medical care.

In particular, seat belts and helmet laws have been effective in reducing spinal cord and head injuries that require intense rehabilitation. If laws are enacted that strictly regulate the use of tobacco, we could look forward to a marked reduction in amputations of limbs caused by peripheral vascular disease as well as the need for rehabilitation services of persons crippled by cardiac disease.

Third, State and Federal legislatures pass rules and regulations that cause significant expense to health care providers, without concurrent additional revenues to cover the cost of implementation.

One example of this is the requirement to establish more extensive morbidity and mortality reporting by health care providers.

These new reporting requirements are costly, and providers are not reimbursed for the additional new costs associated with implementing them.

Fourth, insurance-managed care programs have resulted in a decrease in patient admissions as well as a decrease in average length of stay. These factors have resulted in lower occupancy and less revenue. The loss of revenue has required cost cutting that, in many situations, could affect patient quality of care and has placed hospitals at risk for their survival.

Although some of the reduced utilization is necessary and appropriate, in my opinion, some HMO's are forming monopolies that frequently force providers to accept fees that are below those set by the government.

For example, in Pennsylvania, a new Worker's Compensation Act, Act 144, dictates that providers of health care will be paid at a rate of 113 percent of Medicare reimbursement. Some insurance companies in our area provide medical insurance to a large number of companies with many employees.

These insurance companies, in turn, insist that hospitals and physicians accept fees as much as 20 percent below that dictated by the State. Out of fear of losing further patient volume, health care providers have accepted these terms even though the fees may be below their costs.

Clearly, these practices must be stopped. No group, no matter how large, should force a provider to accept fees below those considered appropriate by the State. This simply results in reduced patient care quality and eventually the destruction of the financial health of providers.

Another negative effect of managed care is the redirection of patients away from traditional health care providers. When the Medicaid Managed Care program became effective in July of 1994, the contractors for this program forced patients requiring rehabilitation services following joint replacement to be sent to nursing homes rather than comprehensive medical rehabilitation programs.

Such action undermines patient quality of care, as well as the financial stability of facilities equipped to handle these conditions effectively. Nursing homes have not traditionally provided the scope and intensity of care needed to rehabilitate patients with functional impairments and co-morbidities.

They also provide limited physical therapy and usually have minimal access to occupational therapy and other ancillary services. Nursing centers also do not have the sufficient staff-to-patient ratios normally found in rehabilitation centers. They also do not train their nursing staff in rehabilitation care to the same extent as rehabilitation hospitals, thereby increasing the risk of post-surgical complications.

I am not suggesting that nursing homes shouldn't be allowed to accept these type of patients. I am suggesting that such level of care be used only when clinically appropriate, and by and large, most of these types of patients are better cared for in a comprehensive rehabilitation center.

Although the cost of care in a rehabilitation facility is greater than the cost of care in a nursing center, the rehabilitation centers

are mandated by the State to have higher staffing ratios and larger facilities than nursing homes.

Fifth, medicine today has changed dramatically from 50 years ago when my father entered practice. It has changed. In 1994 as a result of the malpractice crisis, physicians must practice defensive medicine to such an enormous extent that it is almost comparable with a paranoia.

This adds significant costs to the patients' care and has overburdened the hospital's ability to provide cost efficient care. This has added to our hospital's deteriorating financial condition.

In addition, insurance companies are demanding that doctors justify every treatment or admission to the hospital. This inappropriately consumes valuable time that could have been spent effectively treating patients.

I have recommendations——

Mr. WAXMAN. The whole statement will be in the record.

[The prepared statement of Dr. Bonner follows:]

STATEMENT OF FRANCIS BONNER, JR.

Good morning, my name is Francis Bonner, Jr. I am a physician with a specialty in Physical Medicine and Rehabilitation. Until its closing on May 18, 1994, I served as Sacred Heart Hospital's director of the Department of Physical Medicine and Rehabilitation.

I appreciate the opportunity to be here today so that I can explain why I believe Sacred Heart Hospital's closure occurred. My remarks throughout this presentation will focus on what I know best. That is, from the perspective of rehabilitation services.

Before I describe why I believe the hospital closed, allow me to briefly try to convey to you the effects of the hospital's closure on my patients, our resident physicians in training, the hospital's staff, physicians, and the Norristown community.

First, the hospital's closure greatly affects rehabilitation patients from our region that will now be required to travel another ten miles to the nearest full-service rehabilitation center. Contact with family members – who are so instrumental to a rehabilitation patient's recovery – will be greatly limited by a round trip of over twenty miles. When a rehabilitation patient's condition is associated with an acute injury or illness, continuity with their family physician will also be difficult.

Second, our rehabilitation residents' training could have also been significantly affected by this closure. We train

fifteen rehabilitation residents. These are young doctors who are counting on us for their medical training – a training that involves many years of highly-specialized and very costly education. A set-back such as this could leave these persons professionally and financially at great risk. We are lucky that Graduate Hospital has assumed full responsibility for these physicians in training and their training program can continue without diminution in quality.

Third, the hospital employed approximately 850 persons. Approximately 150 of them were associated with the hospital's rehabilitation services. These persons counted on us for their family's economic well-being, in particular those who were single parents or the sole wage-earner in their families.

Fourth, physicians who specialize in rehabilitation medicine and our community as a whole will be affected by this closure. Specifically, the physicians will need to travel greater distance to treat their patients in the more distant full-service rehabilitation centers. This will eventually erode our community's ability to hold on to these physicians. Gradually, a broad array of other non-hospital rehabilitation services will flow out of our immediate area, leaving the community with significant gaps in the continuum of care.

Now allow me to turn to the reasons why I believe the hospital closed. In assessing these reasons, it is important to examine the healthcare environment locally in Norristown, and nationally.

On a local level, competition between the three general medical hospitals in the Norristown area has been fierce. What has often been referred to as "in the interest of our community" might more accurately be described as

"institutional self-interest." This self-interest resulted in duplication of services and technology.

Not only did the Norristown hospitals compete among each other, they also face stiff competition from large Philadelphia academic medical centers. Norristown is only forty minutes away from Philadelphia – one of the world's most sophisticated medical marketplace. In recent years we have witnessed movement by these centers into suburban communities in efforts that are described as "outreach," but in reality, reflect their need to capture market share to insure their continued existence.

Examining the national healthcare environment reveals several trends that had dire consequences for Sacred Heart Hospital and Rehabilitation Center. Many of these trends involved decreased utilization of acute hospital services. The trends that I believe had the greatest effect on the hospital's closure are as follows:

First, advances in medical science and technology have resulted in shortened hospital stays. This, combined with the rapid growth of ambulatory care for services previously performed only on an inpatient basis has resulted in fewer acute care beds being used throughout the country.

Second, enlightened legislation, such as those that require the use of seat belts, helmets laws, new food labeling requirements, and hopefully, strict regulation of the tobacco industry, will lessen our need for medical care. In particular, seat belts and helmet laws already have been effective in reducing spinal cord and head injuries that require intense rehabilitation. If laws are enacted that strictly regulate the use of tobacco, we could look forward to a marked reduction in amputations of limbs caused by peripheral vascular disease as

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well as the need for rehabilitation services of persons crippled by cardiac disease.

Third, state and federal legislatures pass rules and regulations that cause significant expense to healthcare providers, without concurrent additional revenues to cover the cost of implementation. One example of this is the requirement to establish more extensive morbidity and mortality reporting by healthcare providers. These new reporting requirements are costly, and providers are not reimbursed for the additional new costs associated with implementing them.

Fourth, insurance managed care programs have resulted in a decrease in patient admissions as well as a decrease in average length of stay. These factors have resulted in lower occupancy and less revenue. The loss of revenue has required cost cutting that, in many situations, could affect patient quality of care. It also has placed hospitals at risk for their own survival.

Although some of the reduced utilization is necessary and appropriate, in my opinion, some HMOs are forming monopolies that frequently force providers to accept fees that are below those set by the government. For example, in Pennsylvania, a new Worker's Compensation Act (Act 144) dictates that providers of healthcare will be paid at a rate of 113% of Medicare reimbursement. Some insurance companies in our area provide medical insurance coverage to a large number of companies with many employees. These insurance companies, in turn, insist that hospitals and physicians accept fees as much as 20% below that dictated by the state. Out of fear of losing further patient volume, healthcare providers have accepted these terms even though the fees may be below their costs.

Clearly, these practices must be stopped. No group, no matter how large, should force a provider to accept fees below those considered appropriate by the state. This simply results in reduced patient care quality, and eventually, the destruction of the financial health of providers.

Another negative effect of managed care is the redirection of patients away from traditional healthcare providers. When the Medicaid Managed Care Program became effective July 1, 1994, the contractors for this program forced patients requiring rehabilitation services following joint replacement to be sent to nursing homes rather than comprehensive medical rehabilitation programs. Such action, undermines patient quality of care, as well as the financial stability of facilities equipped to handle these conditions effectively. Nursing homes have not traditionally provided the scope and intensity of care needed to rehabilitate patients with functional impairments and co-morbidities. They also provide limited physical therapy and usually have minimal access to occupational therapy and other ancillary services. Nursing centers also do have the sufficient staff to patient ratios normally found in rehabilitation centers. They also do not train their nursing staff in rehabilitation care to the same extent as rehabilitation hospitals, thereby increasing the risk of post-surgical complications.

I am not suggesting that nursing homes should not be allowed to accept these types of patients. I am suggesting that such level of care be used only when clinically appropriate, and by and large, most of these types of patients are better cared for in a comprehensive rehabilitation center.

Although the cost of care in a rehabilitation facility is greater then the cost of care in a nursing center, the

rehabilitation centers are mandated by the state to have higher staffing ratios and larger facilities that nursing homes. In doing so, the state implicitly agrees that rehabilitation patients need a higher intensity of care, therefore many patients currently being referred to nursing centers are not receiving the optimal care they need. If the state allows managed care providers to arbitrarily exclude any classification of patients from rehabilitation centers, gradually, rehabilitation centers will be faced with serious financial problems, thereby threatening their long-term survival. Our society cannot allow to have healthcare decisions based solely on costs. When decisions are based on costs, the patient loses and the health provider loses. The only winner in such cases are the shareholders of the for-profit managed healthcare insurance companies.

Fifth. Medicine today has changed dramatically from fifty years ago when my father entered practice. In 1994, as a result of the malpractice crisis, physicians must practice defensive medicine to such an enormous extent that it is almost comparable with paranoia. This adds significant costs to the patients' care and has overburdened the hospital's ability to provide cost efficient care. This has added to our hospital's deteriorating financial condition. In addition, insurance companies are demanding that doctors justify every treatment or admission to the hospital. This inappropriately consumes valuable time that could have been spent effectively by treating patients. This also affects the financial condition of the hospital because a great deal of time is spent on non-clinical issues such as pre-admission approval and utilization review.

Finally, allow me to share my thoughts about governance in not-for-profit community hospitals. Governance in these institutions is problematic. These hospitals are governed by

boards that are composed of well-meaning individuals who serve without pay for the good of the community. These board members deserve our gratitude for their service and we have an obligation to help them with this service by providing on-going educational programs on matters of healthcare relative to their institutions. Quality assurance standards for chief executive officers and administrative staff members that enable the board to perform meaningful examination of performance need to be followed. The role of hospital auditors should include the education of board members on interpretation of the financial records and statements that will allow those members to critically assess performance as well as the financial condition of the institution.

If I may, I would like to offer the following recommendations:

One. We must provide adequate governmental and consumer oversight of the health insurance industry so that patients will not be denied access to appropriate care.

Two. We must streamline the bureaucracy so that more time is spent on productive patient care and less time on unproductive paperwork.

Three. We must address the issue of malpractice. Physicians must be allowed to practice without the intimidation of frivolous lawsuits. We must find a better way to ensure high quality medical care and still allow for appropriate malpractice when true malpractice occurs.

Four. We must consider legislation that provides certain requirements for educating and training the boards of not-for-profit healthcare institutions. This legislation should provide

funding for education and training as well as penalties for not complying with JCAHO standards.

In conclusion, for more than fifty-eight years this Norristown community was served by this hospital and its sponsor, the Missionary Sisters of the Most Sacred Heart of Jesus. Their mission was to embrace with love and compassion all those who presented themselves for medical care. The Sisters' philosophy of care for all without regard for ability to pay permeated the entire organization and created a somewhat unique corporate culture in a society dominated by concern for the "bottom line."

Sacred Heart Hospital offered an excellent rehabilitation program. This program was started more than forty years ago by my father, the late Francis J. Bonner, M.D., and it has served as a model for the healthcare industry. It enjoyed a fine reputation and was fully accredited by the Joint Commission on the Accreditation of Healthcare Organizations and the Commission on the Accreditation of Rehabilitation Facilities.

It is truly unfortunate that Sacred Heart Hospital and Rehabilitation Center ran out of time and money before it could complete the plan it initiated for consolidation with Suburban General and Montgomery Hospitals. The closing of Sacred Heart has left a void that needs to be quickly filled. I ask you to demonstrate your continued interest in the reinstatement of medical services and jobs at Sacred Heart Hospital and Rehabilitation Center by facilitating whatever regulatory requirements are necessary to accomplish this end.

Thank you for the opportunity of meeting with you this morning.

Mr. WAXMAN. Let me ask you a question, Dr. Bonner. How much of the problem at Sacred Heart Hospital was due to the fact that people were uninsured or the hospital was getting lower reimbursement because it was a public insurers program that covered them?

Mr. BONNER. I am not privy to books and records and the financial statements of the hospital, but I know there were contracts signed with managed care organizations that were very heavily negotiated contracts. Rumor was that these contracts reimbursed the hospital at a level below their costs and were difficult for the hospital to meet the terms of those contracts.

Mr. WAXMAN. So one of the problems of hospitals is that they have a certain part of their patient population for which they are not going to get any money if they are not insured and then we have people who are there in some managed care program for which they have been forced to give deep discounts and hospitals are struggling with this new world of changes in the marketplace, some of which still leave large numbers of people uninsured and hospitals have to give them care, especially if they have an emergency facility; is that right?

Mr. BONNER. Yes. The point in terms of managed care is that the Delaware Valley is a great medical marketplace. Of our hospitals, I think two made profit at all last year. If you look at the insurance companies in our area, they are all doing extremely well and those dollars are dollars that are coming out of our health care system, coming away from patients and providers.

Mr. WAXMAN. That is clearly a lesson we have to keep in mind as we look at health care reform and future of medicine in this country. The three of you as employees of the hospital are now faced with circumstances of many Americans when they lose their job. You worry about your benefits, Ms. Watson, about your pension benefits.

One of the issues in health care reform is what happens to health care benefits when people change jobs or lose their jobs or are temporarily out of the work force. Have you had any success in making sure that you are protected.

Does the hospital provide, aside from what is required under law for another year—what is your status in health care benefits for yourselves? Ms. McClatchy.

Ms. MCCLATCHY. Thank you, Mr. Chairman.

My personal experience regarding the health insurance, the coverage I had chosen, and it was my choice, was a managed health care contract. It was to cover my husband and myself.

My husband is retired and I am the primary income person in our family. Our medical coverage was terminated on May 31st and in order for me to meet basic minimum general coverage, I guess is how it is referred to, without the privileges of group benefits, I would spend 2—well, almost 3 weeks of my unemployment compensation per month to obtain coverage for my husband and I, which wouldn't leave enough for us to eat or pay mortgage.

Mr. WAXMAN. So you lost your health insurance benefits as soon as you lost your job?

Ms. MCCLATCHY. No, sir. I lost my job on May 18th and I was told the contract was paid through May 31. With that, I lost a pre-

scription program and my husband, as most people that worked at Sacred Heart know, has an extensive medical history.

Now we are paying for the medication and so I cannot afford in a month to pay for medication and to pay for health insurance and eat. I need to make a choice.

Mr. WAXMAN. How about your situation with health insurance?

Ms. WATSON. I was very fortunate in that my husband could cover me with insurance immediately so I did not have the problem. The problem was with the dental. We were informed on the last day that the dental insurance would be covered until the end of May. However, we received a notice the next week that it was discontinued in February. Of course, we unknowingly went ahead and got care not knowing we weren't covered with insurance.

Ms. MARGOLIES-MEZVINSKY. Retroactively, too; correct?

Ms. WATSON. Until the end of February, we were covered.

Ms. NOVIA. I am covered under my husband's insurance also.

Mr. WAXMAN. As Congresswoman Margolies-Mezvinsky mentioned in her opening statement, the health care market is changing very rapidly. We are seeing changes that are putting hospitals at greater risk and these changes might well bring about some hospital closings in the future. But how would any of you that want to respond to this—how do you think these kinds of things should have been handled?

Do you think there is a way to write about these changes in a more appropriate way to make a transition? How do you think this closure should have been managed and what kind of help should be available to you now?

Ms. MCCLATCHY. Sir, if I might, please, I would like to have been prepared for termination of employment. I was one of 600-plus nurses that were dumped on to the job market. I probably would have been more attentive to making current my resume which we know we are accountable to do and I had not done.

Networking, which is the proven way of obtaining jobs, was not available because I had over 600 people competing in that network with me. My job search—it will be 12 months on the 18th. I have had one job offer, and it is going to require my husband and I moving to North Carolina.

I have to sell a home. I have to be away from my husband to start a job. He is going to sell the home.

Mr. WAXMAN. So as we look at the——

Ms. MCCLATCHY. I could give you a lot of good ideas of what should have been.

Mr. WAXMAN. One good idea is not just to let the market take place and changes go about, however they are going to fall, but there is a human element, people involved, and actions shouldn't be taken so abruptly to leave people so much in the lurch.

Ms. Margolies-Mezvinsky?

Ms. MARGOLIES-MEZVINSKY. You briefly mentioned in your testimony that there were some employee meetings which were held by the hospital administration to counter the rumors of closure.

Could you give us a brief description of what these meetings were like, where they were held, when they were held, and what kinds of answers you got to your questions?

Ms. WATSON. Due to the many rumors that were circulated within the hospital, the president of the hospital, Mr. Walsh, held a series of meetings which started last fall and ended just a few weeks before we closed. At all the meetings we were told that the hospital would merge with other hospitals in the community. We were also told—I was reassured that we would not close at all these meetings.

I attended three meetings. Even at the last one in May, which was just a few weeks before we closed, I was assured that we would merge in the fall and I felt we certainly wouldn't close when I being told the merger would go through.

Ms. MARGOLIES-MEZVINSKY. You would think that from the feeling there that it wasn't what you wanted to hear; it is really what you were hearing?

Ms. WATSON. This is what I was hearing. Many questions were asked. The employees were concerned with their plight, there were human resource issues and the issues of combination of services, and we were told that these weren't even discussed in the meetings.

Ms. MARGOLIES-MEZVINSKY. In your position as unit clerk, Carolyn, it is my understanding that your job is to take care of the paperwork of the new admissions to the hospital. Is that correct?

Ms. NOVIA. Right.

Ms. MARGOLIES-MEZVINSKY. On the last day, May 17th, was the hospital accepting admissions?

Ms. NOVIA. Yes, they were.

Ms. MARGOLIES-MEZVINSKY. Tell me about that. In the morning, you were accepting admissions and in the afternoon, you went home——

Ms. NOVIA. It was very confusing because there were rumors circulating that the hospital would be closed by the next day and I myself could not understand why they would admit patients when they were going to evacuate the next day. It just didn't make sense, so I had a twinge of hope that they weren't going to close.

Ms. MARGOLIES-MEZVINSKY. Dr. Bonner, what is your reaction to some of these answers?

Mr. BONNER. Obviously the reaction is compassion for these employees that have been so misplaced by the loss of this institution, compassion for their anxiety and for their welfare. I am just thinking in my own mind of ways that we may help them. Someone like Tina, she and I began working at Sacred Heart over 20 years ago together, a very, very valuable asset to health care in our community. The idea that we have lost her to North Carolina is just a shame.

Ms. MARGOLIES-MEZVINSKY. Dot, in your position as staff nurse, was it ever obvious to you that the hospital was having financial difficulties?

Ms. WATSON. Yes. I realized for many years that the hospital was having financial problems. Again, it was having difficulty obtaining supplies at times and being informed by personnel delivering supplies that the vendors were not being paid.

Payroll deductions into the tax shelter annuities were not being deposited into my account in a timely manner. Medical bills were

not being reimbursed by my insurance carrier. The personnel department informed me that this was an administrative problem.

These bills were eventually paid, but it took some time. Some of the staff called the insurance company and they were told their account was not current and that is why the bills were not being paid. We also had layoffs and an early retirement package about a year before we closed.

Ms. MARGOLIES-MEZVINSKY. Did any of you at any point go to any of the administrators and say on a one-to-one interchange "What is happening? Can you help us out? There are lots of questions here?"

Mr. BONNER. Speaking for myself, I didn't go on a one-to-one basis, but as a member of the Medical Executive Committee. There were increasingly frequent meetings of that committee and during those times concern was expressed about the progress of the merger initially and then the acquisition and we became aware that the situation was becoming more critical, but we were not really faced with the idea of closing the hospital——

Ms. MARGOLIES-MEZVINSKY. In a conversation that we had, you mentioned that you had gone to see one of the sisters in the hospital to have a conversation with——

Mr. BONNER. That was over 1½ years ago.

Ms. MARGOLIES-MEZVINSKY. That you had seen some things that you questioned?

Mr. BONNER. That was with regard to the rehabilitation. A group of investors had returned to a rehabilitation hospital and put money into the community and I thought this was—into the Sacred Heart Hospital—and I thought this was a viable alternative to what was currently happening.

I did discuss this with the chief officer of the Hospital and with Sister Caraceta and had no response from that. I assumed they did not consider it to be appropriate for the hospital at that time.

Ms. MARGOLIES-MEZVINSKY. None of you had any conversations except for the meetings?

Ms. WATSON. Right.

Ms. MCCLATCHY. Excuse me. I would like to state that it was kind of like a known that there were chains to follow, there were appropriate channels for people to seek, and I would not have felt comfortable making a one-on-one contact beyond my senior supervisor who would have been the senior vice president of the Nursing Department—I would not have gone into the administration and said, "Look what is going on."

I wouldn't have chosen that channel and it was kind of like a given. It is almost like a professional courtesy, I guess. I don't know if I am making my point clear, but I would not have walked in and said "What is going on?"

Ms. MARGOLIES-MEZVINSKY. You would have thought that you were going over someone's head and that was not the way one should do that?

Ms. MCCLATCHY. I don't think that I should have been a channel for it to go through the rest of the hospital.

Ms. MARGOLIES-MEZVINSKY. Dr. Bonner, from your viewpoint as a physician in the hospital, what type of role, if any, did the corporate board play in helping facilitate the closure?

Mr. BONNER. I was on the Medical Executive Committee, but I was not on the Joint Conference Committee, which is a committee composed of two members of the Medical Executive Committee, and members of the board of trustees.

I think we have to realize that the role of board members in not-for-profit community hospitals needs to be examined. These are individuals who provide service for the sake of a community and out of the goodness of their hearts to help govern a hospital.

Basically, their knowledge of health care, especially in the complex issues of health care as they exist today, is not great, and they should have periodic educational programs to help them understand issues relative to the institution itself and have educational programs relative to the financial status of the institution.

I am not aware of the activities of the board during the final week or so. I spoke to one or two members who expressed some concern and maybe some distress about things that were going on, but it was kept very quiet as to what the ultimate end was going to be, perhaps because they didn't know themselves.

Ms. MARGOLIES-MEZVINSKY. Do you have any suggestions on establishing guidelines for corporate boards to follow in more or less expanding their responsibilities to the employees, patients, to the community, during a time of financial distress?

Mr. BONNER. I think the first thing we need to do is make sure that boards are aware well in advance that an institution is in distress and although the Joint Commission for the Accreditation of Health Care Organizations provides standards that state education must occur, maybe there needs to be some money to help them do that and some penalties if they don't.

Maybe the role of the financial order of a hospital should also include education of board members so that they can understand the financial health of the hospital and they can understand the reports that the auditors submit to them rather than just sit there and review them. I think things like that might help if they know in advance.

Ms. MARGOLIES-MEZVINSKY. Tina, in reference to your credit history, you mentioned that the untimely closure of the hospital is going to significantly hurt your ratings.

Could you explain that connection more thoroughly, please?

Ms. MCCLATCHY. Yes. I feel that my husband and I probably do what most Americans do. We budget ourselves at a certain level of income and a percentage of our income goes to the essentials, and then we take the luxury items. Anybody can check my credit history. I don't put things on a charge that I don't intend to pay for when the statement comes in at the end of the month and I don't have enough money to pay the statement at the end of the month.

As I have indicated prior to the chairman, it is like I have to make choices. Do I want to eat? Do I want my husband to have his medicine? Do I want to be late with the mortgage payment?

As each of you, I am sure, are aware, it is very easy for somebody to get your credit history. For instance, now with this move to North Carolina, any delay in payment is going to show up when somebody goes to check us for a mortgage loan, and you know, it is just not my fault and I am sick of being imposed upon, and I never lived this way before. I don't know how to do it very well.

Ms. MARGOLIES-MEZVINSKY. Carolyn, Dot, are you finding the same thing?

Ms. WATSON. I am very fortunate that my husband does work and I have not found it as difficult as I think Tina does. But again, everyone has bills and with unemployment, you cannot meet the bills. I still have a loan on the house, but to this point, I have not found it difficult.

My problem is that I probably will be without a position for almost a year before I can even get social security, and that is when I will have the problems.

Ms. MARGOLIES-MEZVINSKY. Did it affect your retirement plan? What kind of effect did it have on your retirement plan?

Ms. WATSON. Very much because my husband and I had planned when we would retire and our income that we would have and of course this was completely destroyed. I know now if I do not get a position, I will be going into my savings. At my age, it is very difficult for a nurse to find a position, even with excellent credentials.

Ms. MARGOLIES-MEZVINSKY. Tell me what it is like—what were you hoping for and how have those plans significantly changed?

Ms. WATSON. I was hoping that when we were 65, that we would be able to retire very comfortably; that with the pension, and plus, I would be accruing more income because I am at a point now where I can save a lot of my income, which I was not able to before because I had six children that had to be educated and this was my time to save for retirement.

Mr. WAXMAN. I want to thank you all very much for your testimony. You have certainly brought home to us that losing a job, finding a hospital for which you have worked so abruptly closed and your lives so abruptly changed can be very, very difficult and in a very personal way I think you have brought this home to us.

It affects the lives of people in very, very serious ways. It would happen anyway, but just the way it happened makes it so much more difficult.

Thank you very much.

Our next witness is David Stevens, who is vice president of MBIA, an investment banking firm located in Armonk, N.Y. MBIA provided Sacred Heart Hospital with access to capital financing for its operations and investments.

Mr. Stevens, we appreciate your being here today and participating in this hearing. Your written statement will be in the record in its entirety.

We want to recognize you, however, to deliver an oral presentation to us.

STATEMENT OF DAVID C. STEVENS, VICE PRESIDENT/MANAGER, GENERAL SURVEILLANCE DEPARTMENT, MUNICIPAL BOND INVESTORS ASSURANCE CORP.

Mr. STEVENS. Thank you, Mr. Chairman and Congresswoman Margolies-Mezvinsky. Before I proceed, I have prepared a 9-minute oral presentation. I also have a very short one. I prefer to give the 9 minute one because I think the details are important.

Mr. WAXMAN. Go ahead.

Mr. STEVENS. Good morning. My name is David Stevens. I am vice president and manager of the General Surveillance Department of Municipal Bond Investors Assurance Corporation, or MBIA for short. I will present an abbreviated version of a longer written testimony submitted for the record.

MBIA's business is to insure municipal bonds issued by cities, airports, colleges, hospitals and other not-for-profit entities. The issuers benefit from the lower interest rates that can go against our AAA rating. Bond issuers and taxpayers in Montgomery County have saved $13 million in interest costs on their MBIA-insured bonds.

Investors, who are individuals and institutions across the country, benefit because MBIA pays the scheduled principal and interest that the issuer cannot pay. My department reviews financial reports from the issuers whose bonds we insure. If the financial results appear very weak, we work with the issuers to stabilize their finances. For example, we may help by identifying industry experts who can help solve problems.

We do not and legally cannot step in to manage the business affairs of institutions whose bonds we have insured. MBIA insures Sacred Heart Hospital bonds because in 1989 we acquired another bond insurance company, Bond Investors Guarantee. The original bond issue insured by BIG occurred in February 1987.

Sacred Heart's financial statements for June 30, 1992 were reviewed by General Surveillance with some concern because they indicated significant bottom line losses. Our concern mounted when even larger losses were posted as of June 30, 1993. We initiated discussions with hospital management to learn what was ailing Sacred Heart.

What was wrong? First, like all hospitals, Sacred Heart had to deal with well publicized cost pressures affecting the health care industry.

Second, the Norristown market was extremely overbedded. For example, from June to December 1993, only 291 of 564 hospital beds in Norristown were occupied on average.

The excess number of beds, around 250, is about the size of either Sacred Heart or Montgomery. In August of 1993, Sacred Heart's management told MBIA that they were trying to deal with their problems by, one, negotiating a merger with Montgomery and Suburban General; and two, reducing costs substantially to minimize Sacred Heart's financial distress while the merger was being consummated.

This seemed reasonable to us. We waited a few months to see what the results would be. By November 1993, we had become increasingly concerned because the hospital's finances were continuing to deteriorate and patient volumes were not improving. Our visits to the hospital in December, January and February focused on the progress of the merger and the steps management took to cut costs and improve cash flow.

During this period, the hospital farmed out its business office operations to a company called HFS and sold, with our eventual but somewhat reluctant consent, some of our collateral to raise cash.

In March 1994, the hospital president and chief financial officer and financial advisor asked MBIA to lend Sacred Heart $2.5 mil-

lion to help it survive. Without such a loan, they told us that they believed the hospital could only last a number of weeks. They in turn would pursue an accelerated merger with Montgomery. How did we view this request?

First, we don't normally make loans. We insure bonds. Still, we were willing to consider this extraordinary request if making a loan that would preserve the investment of the bondholders.

A key point was the loan amount. MBIA had $25 million of bonds at risk. A modest loan of $2 milllion to $3 million to save $25 million would clearly be prudent. Making a loan would have the added community benefit of saving jobs and an institution with an important role to play in Norristown. In short we wanted to make the loan.

On April 19, we sent Mr. Patrone, the hospital chairman, a letter outlining possible terms of conditions of the loan and indicated that we would consider amounts up to $3½ million.

Over the next several weeks we spent hundreds of thousands of dollars in consulting and legal fees to validate the loan request and our staff put in untold hours working up legal documents to make the loan possible. We told hospital management that a condition of our considering the loan would be for our consultants, the Hunter Group, a highly skilled group of hospital experts, to validate the loan request.

In other words, we wanted our consultants to assure us that $2 million to $3 million was the amount of money needed to see the hospital through the merger. This validation would occur through the hospital meeting the following requirement in the April 19th letter: "Development of an operating budget and a forecast of operating needs on which disbursements under a credit facility would be based."

In effect, the Hunter Group had to validate two numbers. One, the number of dollars needed to operate the hospital; and two, the number of days or weeks or months it would take to merge. The longer it would take to complete a merger, the more money MBIA would have to loan the hospital to survive the merger process.

During the next several weeks, the Hunter Group studied the hospital's operations, management, governance and finances. The hospital provided us various projected operating budgets for the next several months, but the hunter group advised us in each case that elements of the projections were incorrect.

On May 8, MBIA finally received from hospital management a financial projection that the Hunter Group felt was reasonably valid if still somewhat inaccurate. I have attached it to my written testimony.

I have circled two key numbers on the projection which estimated cash needed to run the hospital from May through July 29, 1994. One number was the loan request and this projection calculated at $2.25 million.

The second key number shows a bank overdraft at the end of the period of $2.2 million. So the true amount of cash needed was the loan of $2.25 million plus the overdraft of $2.2 million, or $4.45 million. This was nearly double the $2.5 million that the hospital had originally said they needed. It was nearly $1 million more than the maximum amount we said in our letter we would consider.

The Hunter Group also felt that the July 29 date for consummating a merger with Montgomery was highly optimistic. Mergers are tough to negotiate and completely unpredictable as to the timing of regulatory approvals even in distress situations like the one in Norristown.

One can never predict who will object to a merger and cause further delay. A 12-week delay, which we felt was not at all unlikely, could double the amount needed to perhaps $9 million.

So we concluded that the money needed to keep the hospital afloat was not $2.5 million or $3.50 million, but perhaps as much as $9 million or $10 million, or more. With great reluctance we decided that we could not grant the loan request.

We told the hospital's president and chief financial officer and certain members of the executive committee of the board, legal counsel and financial advisor of our decision on Tuesday, May 10. A week later, we offered the same group an alternative, a loan of $700,000. We believed that the hospital's license could be in jeopardy if it closed completely, and also felt the hospital would need funds to effect an orderly shutdown of its operations which appeared to be the only course left to management. By that, we mean the possibility of avoiding a sudden announcement, immediate rather than staggered layoffs, and the potential of harm to patients in a atmosphere of panic.

We thought the hospital could be used first to keep open some relatively financially healthy area of the hospital like the rehabilitation center, which would preserve a license of the hospital; second, to fund security and plant maintenance; and third to provide some partial payroll.

A key condition of our loan was that the hospital would agree to a State court receivership rather than bankruptcy. This in our view would result in better treatment of our claims as a creditor, would reduce costs, would have put the hospital under different management, and would enhance the hospital's value.

Management declined the loan, announced the closure of the hospital, and subsequently filed for bankruptcy protection. Was MBIA right in judging that $2.5 million was not enough to see the hospital through to the merger?

Let's look at the record. The hospital collected $2 million in advances from Medicare and another $1 million from U.S. Healthcare in mid-May. Those funds were spent in a few days as the final payroll was made and back payroll withholding taxes were paid off. If it took the hospital 2 or 3 days to blow through this $3 million, why does anybody really think that our $2.5 million would have lasted through the end of July?

In summary, MBIA did its best to help, but were unable to rescue the situation. The bondholders will be paid by MBIA, which is on the hook for $25 million. We have sympathy for the people who lost their jobs and we sincerely hope that the sale of the former Sacred Heart facility through bankruptcy will result in the generation of new jobs in Norristown.

With that, I will be happy to answer questions.

[The prepared statement of Mr. Stevens follows:]

TESTIMONY BEFORE FIELD HEARING OF THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

July 11, 1994
David C. Stevens
Vice President/Manager, General Surveillance Department
MBIA Corp., Armonk NY

Good morning. My name is David Stevens. I am the vice president and manager of the General Surveillance Department of Municipal Bond Investors Assurance Corporation or MBIA for short.

MBIA is in the business of insuring bonds. Just as some companies insure against loss of houses or cars, we insure investors against a loss of interest and principal on the bonds in their nest eggs.

Most of the bonds we insure are municipal bonds issued by cities, states, counties, airports, colleges, utilities, and hospitals. Bond insurance benefits the bond issuer because their bonds carry our triple-A rating and that means they pay lower interest rates. Bond issuers -- and ultimately taxpayers -- in Montgomery County have saved $13MM in interest costs on their MBIA-insured bonds. Probably most importantly, the investor benefits because if the municipality or college or hospital cannot make a bond payment, MBIA pays the scheduled principal and interest as due to bondholders.

Who are the bondholders? They are individuals and institutions who are scattered all across the country, who lend their money to hospitals, colleges, and governmental entities in good faith, and who in all likelihood have no direct association with the issuer or its operations. Ultimately our bondholders are retired teachers, firemen, doctors, nurses, farmers, and small businesspeople -- a cross section of American citizens.

MBIA's General Surveillance Department has two principal functions. One, we review periodic financial reports from the issuers whose bonds we have insured. Two, in cases where those issuers have very weak financial results, we attempt to work with the issuer to stabilize their finances. For example, often we assist issuers who have encountered financial difficulties by identifying and calling in industry experts who can help solve the problem. MBIA does not act as a manager of the financial or operational affairs of the facilities involved, for example, in this case Sacred Heart Hospital. It was in my capacity as the head of the General Surveillance Department that I became familiar with Sacred Heart Hospital.

MBIA came to insure some of the bonds issued by Sacred Heart Hospital through its acquisition in 1989 of another bond insurance company, Bond Investors Guaranty or "BIG." The original bond issue insured by BIG occurred in February, 1987. The issue was for a total of $30MM which was to be used by the Hospital to refinance various bonds previously issued in connection with a multi-phase construction and renovation project for the Hospital, to fund certain necessary reserve funds and for the purchase of data processing hardware and software.

2

Sacred Heart came to the Surveillance Department's particular attention when we reviewed financial statements for the fiscal year ended June 30, 1992; these statements revealed bottom line losses. Our concern mounted when the extent of financial losses for the fiscal year ended June 30, 1993 became known to us later in the summer of 1993. We initiated meetings with the management of the hospital and started to study what was ailing Sacred Heart.

Our view is that the Hospital's problems can be summarized in two general areas -- problems common to the entire hospital industry and problems specific to Norristown.

With respect to general industry problems, Sacred Heart like most other hospitals was having to cope with changes in insurance reimbursement practices and accelerating medical technology. Both of these influences act together to reduce the amount of time people are spending in hospitals. This in turn means hospitals have to be more and more competitive in order to attract their fair share of patients.

With respect to area-specific problems, let me just point out one key statistic. In the period June to December 1993, there were 564 hospital beds in Norristown and on average only 291 of them were occupied. In other words, the insurance reimbursement and medical technology changes had made Norristown a city where competition for patients was particularly fierce. The City only needed around three hundred hospital beds. The excess number of beds -- around 250 -- is about the size of each of two of Norristown's three hospitals, Sacred Heart and Montgomery.

At a meeting in August 1993, Sacred Heart's management told MBIA that they were coping with these problems in two general ways. One, they were negotiating a merger agreement to create a single hospital from among the three hospitals in Norristown. Two, they had reduced costs substantially at Sacred Heart in order to minimize its financial distress while the merger was consumated.

This seemed like a reasonable response to us and we waited a few months to observe the results of the steps taken. By November and December 1993 we had become increasingly concerned because the Hospital's finances were continuing to deteriorate and patient volumes were not improving.

Our visits to the Hospital in December, January, and February focused on the progress of merger discussions and certain steps management took to cut costs and improve cash flow. It was during this period that the Hospital farmed out its business office operations to a private firm, HFS, and sold, with our eventual and somewhat reluctant consent, some of our accounts receivable collateral to raise cash.

3

In March, 1994, the Hospital president, chief financial officer and financial advisor asked MBIA to make a loan to it in the amount of $2.5MM to assist it in getting through the next few months. Without such a loan they told us that they believed that the Hospital could only last a number of weeks. Management told MBIA that it believed that it would soon merge with Montgomery and Suburban General Hospitals and that if we could help them get to the merger, their financial woes would end.

Let me try to give you some perspective on how we viewed the request. First, we don't make loans as a normal course of business -- we insure bonds. Second, we would be willing to consider making this extraordinary loan if it would preserve the investment of the bondholders. A key point in deciding this issue was the amount of the loan. Only $5MM of the original $30MM in bonds had been repaid at this point, so MBIA had $25MM at risk. A modest loan of $2MM to $3MM to save $25MM would clearly have been a prudent business decision. Making the loan would have the added community benefit of saving jobs and an institution with an important role to play in Norristown.

In short, we wanted to make this loan. As evidence of our seriousness, we sent Mr. Patrone, the Hospital Chairman, a letter dated April 19, 1994, outlining possible terms and conditions of the loan and indicated that we would consider amounts up to $3.5MM. As evidence of our sincerity, let me state that over the next several weeks we spent hundreds of thousands of dollars in consulting and legal fees to validate the loan request and our staff put in untold hours working up legal documents to make the loan possible.

We do have obligations to our shareholders to make intelligent and well reasoned business decisions, however, so we told Hospital management that a condition of our considering the loan request would be for our consultants, the Hunter Group, a highly skilled group of hospital experts, to validate the loan request.

By validate the loan request, I mean that we wanted our consultants to assure us that two to three million dollars was the amount of money needed to see the Hospital through the merger. If the amount of money needed were, for example, $20MM, it would not be a sound business decision to make the loan. If the number were in the neighborhood of two to three million dollars, we felt the loan would be in MBIA's best interests as well as the Hospital's. This validation would occur through the Hospital meeting the following requirement in the April 19 letter: "Development of specific policies and procedures for the turnaround of Hospital operations, including development of an operating budget and a forecast of operating needs on which disbursements under the credit facility would be based."

In effect the Hunter Group had to validate two numbers -- one, the number of dollars needed to operate the Hospital and two, the number of days, weeks, or months it would take to merge. The longer it would take to complete a merger, the more money MBIA would have to loan the Hospital to survive the merger process.

4

During the next several weeks the Hunter Group studied the Hospital's operations, management, governance and finances. The Hospital provided at various times projections of its operations over the next several months but the Hunter Group advised us that various elements of the projections were incorrect.

On Mothers' Day, May 8, 1994 MBIA finally received from the Hospital management team a financial projection that the Hunter Group felt they could validate. I have attached it to my remarks for the review of interested parties. I have circled two key numbers on the projection,which estimated cash needed to run the hospital from May 6 through July 29, 1994.

One number was the loan request, which in this projection was calculated at $2.25 MM. A second key number is at the bottom of the page showing cash at the end of the period in the amount of **negative** $2.2MM. What this means is that the true amount of cash needed was the loan of $2.25MM plus the cash overdraft of $2.2MM -- or $4.45MM. This was nearly double the $2.5MM the Hospital had originally said they needed. It was nearly $1MM more than the maximum amount we said in our letter we would consider.

Just as important, the Hunter Group felt that the July 29 date for consummating a merger with Montgomery Hospital was highly optimistic. Mergers are difficult to negotiate and completely unpredictable as to the timing of regulatory approvals, even in distressed situations like the one in Norristown. A twelve week delay, which we felt was not at all unlikely, could double the amount needed again, to perhaps $9MM.

In short, the amount of money needed to keep the hospital afloat was not $2.5MM or $3.5MM but some much larger number, perhaps as much as nine or ten million dollars or even more. With great reluctance we decided that we could not grant the loan request.

We met with the Hospital's president, chief financial officer, certain members of the executive committee of the Board, legal counsel and financial advisor on Tuesday May 10 and notified them of our decision and the reasons for it. While we could not agree to the original request, a week later we did offer the same group an alternative.

We believed that the Hospital's license could be in jeopardy if it closed completely and also felt the Hospital would need funds to effect an orderly shutdown of its operations, which appeared to be the only course left to management. By that we mean the possibility of avoiding a sudden announcement, immediate rather than staggered layoffs, and the potential of harm to patients in an atmosphere of panic.

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To that end on May 17 we offered management a loan of approximately $700,000. We anticipated that some perhaps relatively financially healthy area of the Hospital, like the rehab center, might remain open to preserve the license of the Hospital and that additional funds could be used to fund security and engineering operations. A key condition of our loan was that the Hospital would agree to a state court receivership rather than bankruptcy. This in our view would result in better treatment of our claims as a creditor, would reduce costs, would have put the Hospital under different management, and would enhance the Hospital's value.

Management declined the loan, announced the closure of the Hospital, and subsequently filed for bankruptcy protection.

A fair question with hindsight might be, was MBIA right in judging that $2.5 million dollars was not enough to see the Hospital through to a merger? I think events prior to the bankruptcy filing bear our decision out as the right one. Hospital management told us in mid May that they had received a prepayment from Medicare in the amount of $2MM and another $1MM prepayment, which they characterized as a no strings attached gift, from US Healthcare. Those funds were expended in a matter of two or three days as a final payroll was made and back payroll withholding taxes due the IRS as well as state and local taxing agencies were paid off. If it took the Hospital two or three days to blow through this $3MM, does anybody really think our $2.5MM would have lasted through the end of July?

If I may I would like to close with four observations:

1. We did our utmost throughout this agonizing process to help the Hospital survive but it was ultimately beyond our ability to rescue the situation.

2. Bondholders will be protected and will receive their principal and interest payments from MBIA, which is on the hook for $25MM.

3. MBIA does have great sympathy for those many people who have suffered through the closing of the Hospital -- staff, patients, and the community Sacred Heart served.

4. We hope the sale of the Hospital facility through the bankruptcy proceedings will result in new long term job growth in Norristown.

I will be happy to answer any questions you might have.

SACRED HEART HOSPITAL OF NORRISTOWN
PROJECTED SOURCES AND USE OF FUNDS
FOR THE PERIOD ENDING JULY 29, 1994

received
5/8/94

	5/13	5/20	5/27	6/3	6/10	6/17	6/24	7/1	7/8	7/15	7/22	7/29	Total
Sources of Funds:													
Medicare collections	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	$3,600
Other collections on patient accounts	170 (90)	170	170	170	170	170	170	170	170	170	170	170	2,040
Proceeds from receivables factoring	0	0	0	0	0	0	0	0	0	0	0	0	0
Proceeds from MBIA loan	500	0	350	0	350	0	350	0	350	0	350	0	2,250
Miscellaneous receipts	201	9	49	9	9	9	49	9	9	9	9	49	420
Total sources of funds	1,171	479	869	479	829	479	869	479	829	479	829	519	8,310
Uses of Funds:													
Payroll	171	339	171	339	171	339	171	339	171	339	171	339	3,060
Payroll taxes - current	0	250	0	250	0	250	0	250	0	250	0	250	1,500
Benefits	101	55	217	0	0	55	199	0	0	0	55	199	881
Physician fees	110	0	0	0	110	0	0	0	0	110	0	0	330
Utilities	0	0	0	104	0	0	0	104	0	0	0	104	312
Leases/rents	59	0	15	0	59	0	0	0	59	0	0	0	192
Insurance	0	70	0	0	0	70	0	0	0	70	0	0	210
Debt service	256	0	0	0	256	0	0	0	0	256	0	0	768
Other vendor payments	109	130	130	130	130	130	130	130	130	130	130	130	1,539
Home health contractor	0	48	0	48	0	48	0	48	0	48	0	48	288
Past due taxes	0	173	0	0	173	0	173	0	173	0	173	0	865
Total uses of funds	806	1,065	533	871	899	892	673	871	533	1,203	529	1,070	9,945
Increase (decrease) in cash	365	(586)	336	(392)	(70)	(413)	196	(392)	296	(724)	300	(551)	(1,635)
Cash, Beginning of Period	(591)	(226)	(812)	(476)	(868)	(938)	(1,351)	(1,155)	(1,547)	(1,251)	(1,975)	(1,675)	(591)
Cash, End of Period	($226)	($812)	($476)	($868)	($938)	($1,351)	($1,155)	($1,547)	($1,251)	($1,975)	($1,675)	($2,226)	($2,226)

Mr. WAXMAN. Thank you very much, Mr. Stevens.

Based on your knowledge of the hospital itself, can you tell us what portion of the patients approximately were uninsured or unable to pay for their care, and do you think the level of uncompensated care or charity care was a significant factor in the financial failure of this institution?

Mr. STEVENS. I don't know the answer as far as the percentage. We were listening to your prior questions on that and I asked some of my colleagues. While we don't have that number at the tip of our tongues, our belief is that the uncompensated care in this hospital is about average. Our company insures the bonds of over 600 hospitals.

We don't feel that the level of uncompensated care here is particularly excessive compared to other ones we have seen. So while that may be a factor, we don't think it is an extraordinary factor.

Mr. WAXMAN. We expect with the restructuring of the health care market to see hospitals hard pressed and many to go out of business.

Can you give us some suggestions as to lessons we can learn from this experience that would make such occurrences less abrupt and less disruptive to the patients and the employees?

Mr. STEVENS. Well, I certainly think that the management and the governance of an institution like Sacred Heart has to recognize financial reality early on and try to deal with it early on. There are firms out there who specialize in the turnaround of troubled hospitals.

We hired one to work with us, the Hunter Group, and bringing in this kind of expert help early is sometimes hard for people to do because it may feel like an admission that they can't handle the problem themselves. We think it is a smart thing to do and perhaps having done something like that could have kept the hospital alive through the merger process.

Mr. WAXMAN. Thank you.

Ms. Margolies-Mezvinsky?

Ms. MARGOLIES-MEZVINSKY. In your May meetings with Sacred Heart concerning the loan request, were you meeting with the full corporate board?

Mr. STEVENS. No. We were repeatedly denied access to that board, as was the Hunter Group. We were told that the executive committee was empowered to make the key decisions and that discussions with the full board could cause adverse effects on the merger with Montgomery.

However, I should in fairness state that after repeatedly asking for this, I was told that in either late April or May, a full board meeting was held and the situation was discussed. We never ourselves met with the full board.

Ms. MARGOLIES-MEZVINSKY. In your testimony, you shed some new light on the events surrounding the closure. If your corporation offered the hospital $700,000 the evening of the 17th to bring about a quarterly closure of the facility in exchange for an agreement to take State receivership action rather than bankruptcy, it seems to me that Sacred Heart had an option presented, which would have allowed them to bring about closure in a less traumatic way.

Why then did they not accept the loan? Do you recall any reason that they gave you for declining the corporation's offer?

Mr. STEVENS. I don't recall that they gave a reason for declining the offer. I don't believe they stated a reason. They simply declined the offer, is my recollection.

Ms. MARGOLIES-MEZVINSKY. Do you see any reason why a bankruptcy procedure rather than a State receivership would be a better solution for the hospital?

Mr. STEVENS. We thought the State receivership was better for three reasons. For our interest, we felt that we would be better treated as a creditor.

Second, we thought a receivership could be carried out at lower cost. Attorneys, accountants and administration costs of a bankruptcy in our view are typically much greater than for receivership. Receivership would put the hospital under new management which was something that we decided would have been a good thing at this point.

Ms. MARGOLIES-MEZVINSKY. I have some concerns about the hospital's factoring of receivables. Could you please explain what your understanding is of the relationship between Sacred Heart and Hospital Finance Systems, Inc.?

Mr. STEVENS. I will do the best I can. I would start by saying that basically our knowledge comes through whatever the hospital told us about it and through reading of documents. We don't have any independent relationship with HFS so we are not aware of the company firsthand, although at this point we have met them a couple of times.

We believe that Sacred Heart is the or a major client of this firm in that they engaged in a business relationship with Sacred Heart which had two aspects to it.

One, in effect, the hospital privatized its business office. They subcontracted HFS to run their business office in effect, and that is a decision that is entirely within their purview in which they did not ask our consent to and it wasn't required.

The second aspect of the relationship is factoring, which means borrowing, it is a source of borrowing against future collection of bills. Those collections are part of the collateral security interest of MBIA under the bond documents and to borrow against that, in our view, the hospital needed our consent.

We learned about this after plans were well underway to conduct this factoring and objected. Their bond counsel, I believe, had told them that they did not need our consent. Our counsel called their counsel. The lawyers talked it over and they finally decided to ask our permission.

We studied the issue and decided that this was a necessary thing for the hospital to do because they desperately needed the cash, so we reluctantly approved a $3.5 million factoring on February 24th. We know that the day after that they began factoring, and we believe that they factored in excess of the $3.5 million we approved.

The records on this as on many other issues are somewhat unclear. We believe they factored in excess of the amount that we agreed to.

Ms. MARGOLIES-MEZVINSKY. Mr. Stevens, in looking over the materials you have provided, I have a question about the financial

data figures on the spread sheet. Could you explain to me why under the row for taxes left unpaid, the figure of $173,000 appears every few months across the board?

Mr. STEVENS. The hospital disclosed to us in, I believe it was March, it could be February, that one way they were financing themselves was they were withholding from the IRS and from State and local taxing authorities the withholding taxes of their employees and they were using that basically to finance their operations.

Mr. Gatt, the former chief financial officer, told us that he had arrived at an agreement with the IRS for the repayment of those past-due taxes.

I indicated in my testimony that this financial projection was generally validated but there were inaccuracies in it, and this is an example. We were told that they had a 60-day grace period before any payments were due at all, and then they would pay in installments.

What this financial projection shows is installments beginning immediately of $173,000 in this case. Our understanding was that $1.8 million was withheld from the IRS and from State and local taxing authorities and was owed by the hospital our belief is that the funds were paid with the Medicare advance that occurred in the last week of the hospital's life.

Ms. MARGOLIES-MEZVINSKY. It is my understanding that rather than using the $2 million from Medicare to bring about an orderly closure of the hospital, Sacred Heart chose to pay the IRS off in full even though they already had a reimbursement schedule plan.

Is this statement accurate to you?

Mr. STEVENS. It is accurate as far as I understand it. It is really a question that I am not able to answer with authority. I am reflecting to you what they told me their plans were, so as far as I know that is an accurate statement.

Ms. MARGOLIES-MEZVINSKY. Given all of this, I would like to follow up on something Mr. Waxman asked you. What are the lessons that we should be learning from this? You obviously have a particularly interesting view—I mean sitting back looking at this as someone representing an entity that hurts from this kind of closure—what have we learned from this?

Mr. STEVENS. Well, I think that there are general industry problems that are beyond in some ways anybody's ability to control. For example, medical technology makes hospitalization less necessary than it was 20 years ago and so I think some of these advances are going to make it more difficult for hospitals to compete as we go forward.

The question is how do managements cope with these problems. We would like to see in the management of the hospitals we insure a very proactive, open attitude to work with us. We certainly wanted to work with the management of the hospital to try to solve the problems.

We tried to bring in people that were expert and who could have in our opinion helped solve it. We should try to be more receptive to these kinds of consulting suggestions and work together to resolve the problems.

Ms. MARGOLIES-MEZVINSKY. And your feeling was that there was not a listening on their end?

Mr. STEVENS. I don't want to say that they weren't listening. I think they were. I think there was a resistance. We do not manage the hospital. It is their obligation to manage the hospital and perhaps we were viewed as intrusive in the steps that we wanted to take. I am sure that we were. But our intentions were good and our goals were the same. Our goals were to save the hospital.

Ms. MARGOLIES-MEZVINSKY. Thank you very much.

Mr. WAXMAN. Thank you.

Our next witness is John J. Koresko, who is an attorney representing a number of former employees of Sacred Heart Hospital. We want to thank you for participating in our hearing today, Mr. Koresko.

Your prepared written statement will be in the record in full. What we would like to ask you is to limit the oral presentation to 5 minutes.

STATEMENT OF JOHN J. KORESKO, ATTORNEY IN CLASS ACTION SUIT AGAINST SACRED HEART HOSPITAL

Mr. KORESKO. Thank you, Mr. Chairman.

My testimony today stems from two roles I have occupied since the announced closure of Sacred Heart Hospital.

First, I am the attorney in a class action case filed against Sacred Heart on behalf of former employees. This matter is being transferred from the Montgomery County Court of Common Pleas to the United States Bankruptcy Court for the Eastern District of Pennsylvania so that the employees' class litigation can proceed.

The employees seek claims which now total in excess of $5 million on account of accrued and unpaid vacation wages, sick pay, unused personal holidays, and unpaid insurance and pension benefits. The employees' claim also includes 2 months of regular wages for failure of Sacred Heart to give its employees 60 days notice of termination as required by the WARN Act.

At you know, the hospital gave its dedicated employees a grand total of 24 hours notice before closing.

The second role I occupy today is that of concerned citizen. Although I did not work at Sacred Heart Hospital, the closure of the hospital will have an effect on my family, friends, clients, and others.

Sacred Heart Hospital was my family's hospital. Most of my family were born there. We went there with our broken bones and diseased appendixes. We got our stitches there. And I had to suffer my father's death there. In our community, most people who chose Norristown medical care were either Sacred Heart people or Montgomery people.

I think the Catholic influence of Sacred Heart had much to do with it. As you know, people's perceptions about a level of care have much to do with their recovery. Although no one can say with certainty which hospital gave better care, for the patients, there was an intangible element which made them choose Sacred Heart. At the very least, the prayers on the loudspeakers, celebrations of mass in the Chapel, and the kind faces of nuns made a difference which will sorely be missed.

The things I am going to say are the result of over 2 months of almost non-stop investigation into this matter. My law office has been inundated with telephone calls. Many people seem very willing to tell a lawyer about disturbing things that went on in the last months and days of the hospitals operation.

In contrast, many will not repeat those things in public, for fear of retribution. It has been explained to me that despite laws protecting so-called "whistleblowers" from being fired from a job, it is not the same for people seeking jobs. If a person gets a reputation of not being a "company man", it may be impossible to get future employment. Thus, most people prefer to keep their anger personal.

Therefore, in the statement I give today, I will respect the confidences of my clients. Most everything I have been told appears already in records supplied by the hospital to its employees, its creditors, and to the Bankruptcy Court.

The troubles at Sacred Heart did not suddenly appear like a lightning bolt in 1994. A look at the hospital's financial statements shows that the problems can be traced to the fiscal year ending June 30, 1992, and probably before. In fiscal year 1992, Sacred Heart Hospital generated $43.8 million in revenue. However, it incurred over $55.4 million in expenses, resulting in a net loss for accounting purposes of $1.6 million. $3.3 million was attributable to non-cash items, so there was still potential positive cash flow of $1.4 million, despite the accounting loss. However, the hospital used over $2 million of that money for property purchases. It borrowed another $4 million in order to pay off about $3.8 million in debt obligations. This all resulted in a net cash loss of over $300,000.

The financial statements show the "borrow from Peter to pay Paul" syndrome which affected the hospital. This pattern continued into 1993 and 1994, except that increasingly, employees were being called upon without their knowledge to be the "Peter."

For the year ended June 30, 1993, the picture just got worse. Revenues declined $6.2 million, but expenses increased about $400,000. Thus, the net operating loss increased to $8.2 million. The hospital apparently initiated early retirement and termination actions in that year, and they resulted in an additional loss of over $850,000.

In total, the accounting loss was $8.9 million in fiscal year 1993. When you look at cash flow, the situation was not quite as bad, but not at all good.

Over $3.3 million of the loss was attributable to depreciation and amortization, which are not cash items. The hospital borrowed $650,000 from credit lines, but paid out over $2.3 million on its long-term debts and leases. A shocking thing is that it invested over $1.2 million in other entities it was affiliated with.

However, cash flow was salvaged by two major factors, the hospital had to sell almost $1.8 million of investments, and it collected over $3.8 million of its receivables without replacing them. The result of these transactions was about break-even cash flow.

A simplification of the foregoing analysis renders the following: In 1993, Sacred Heart was cannibalizing its assets in order to pay its bills. It had little money to set aside for equipment and property which was depreciating in value. Most striking of all, payroll relat-

ed costs ballooned to 69 percent of total revenue in fiscal 1993. This was up from 63 percent in fiscal 1992. My experts in hospital management inform me that payroll should be in the range of 45 percent of revenues for a hospital.

Financial problems at Sacred Heart worsened. Employees reported that deductions from their paychecks for the tax shelter annuity plan and credit union were taking over a month to arrive in their accounts. This activity was arguably a direct violation of ERISA as implemented in labor regulations. The hospital management issued apology letters to employees, but the practice continued. These moneys were a free source of credit.

The hospital also engaged in troubling behavior with respect to payroll taxes. Employees who worked in the financial office of the hospital report that on most occasions, the hospital did not have in its possession the amount of its gross payroll. It only scraped together amounts for net payroll.

If an employee regularly earned $1,000 gross and $750 net, he in essence trusted that the hospital possessed and was properly applying the $250 withheld. This was generally not the case in those last months.

Sacred Heart's Federal payroll tax returns for the first quarter of 1994 bear this out. Generally, an employer withholds enough from an employee's pay to meet the employee's tax liabilities; and then the employer turns it over to the appropriate government authority.

The Federal form 941 signed by Anthony Gatt, senior vice president for finance, showed income taxes withheld of $631,638.11 and an employee share of social security and Medicare taxes withheld of $362,758.78 for a total withholding of $994,396.89. The hospital only deposited $530,000 of that money which it was given in trust.

Therefore, the hospital obtained a free loan of $464,396.89 from employees during January, February and March of 1994. This unpaid amount, along with the hospital's FICA and Medicare liability of $362,758.78 resulted in the hospital owing the IRS $827,155.68 on April 27, 1994.

The hospital also owed the Commonwealth of Pennsylvania over $110,000 for State taxes withheld and unpaid on April 14. This means the total amount involuntarily borrowed from the employees' payroll tax withholdings exceeded $570,000. It is believed that this amount was not paid until the hospital persuaded Medicare to advance over $2 million just days before the hospital closed.

On April 15, 1994, the hospital defaulted on its payment attributable to its bond debt in the amount of $594,577.50. When you consider this with the payroll tax problem, over $1.2 million was due and unpaid over a month before the hospital closed its doors. At this point, it was surely inevitable that Sacred Heart would eventually have to shut its doors. At this point, it was surely inevitable that Sacred Heart would eventually have to shut its doors. The decent thing would have been to give at least 30 days' notice of closure.

There is a Federal law called the Worker Adjustment and Retraining Notification Act, also known by its acronym, the WARN Act. This law requires an employer with more than 100 employees to give at least 60 days notice prior to termination, or to pay the

employees' wages and benefits attributable to that period if notice is not given. Of course, the WARN Act was violated in this case.

Sacred Heart's payroll was about $750,000 biweekly, indicating WARN Act damages of $3 million. But where is this going to come from? Sacred Heart is bankrupt. My discussions with Sacred Heart's attorneys reveal that possibly $1 million might be collectible from the bankruptcy estate. Who is going to pay the rest?

In the meantime, I continue to counsel the hundreds of employees who have no insurance and no jobs. Some employees face substantial medical and dental bills for procedures they thought were covered by Sacred Heart's self-funded insurance plan. I have prepared bankruptcy petitions for some. I have witnessed their tears and anguish in my office, in my conference room, and on the telephone. There is not much I can say.

As I stated previously, the community will no doubt suffer. Aside from the jobs lost and the trickle down impacting vendors and business around the hospital, our children will no doubt suffer. Sacred Heart's $33 million payroll resulted in over $330,000 in local income taxes, primarily earmarked for the Norristown School District. This money may not be replaced, unless local property taxes rise. Thus, about 30,000 people in Norristown, East Norriton and West Norriton will suffer.

I suggest that this committee make recommendations to the entire Congress using the Sacred Heart Hospital debacle as a model. The WARN Act needs teeth. There are perhaps two ways to do it.

First, the Act should be expanded to hold officers and directors of employers liable if they do not give the proper 60 days notice. I guarantee you there would be no more closures on 24 hours notice if the individuals who control corporations faced liability.

Second, the WARN Act could be toughened with criminal sanctions for noncompliance. I suggest, however, that civil sanctions may work better. The junk bond kings who went to jail show us that people will gladly trade their liberty if, upon release from prison, millions of dollars wait for them.

Second, serious inquiry must be made about unauthorized use of employee withholding taxes. Although it is a crime, this practice is rarely enforced except in the most egregious cases. In this case, the government eventually got its money, indirectly from Medicare. The law should be amended to require an employer to notify employees if Federal and State payroll taxes are not being remitted timely.

Finally, Federal pension laws should be changed to make it easier for groups of employees to use pension funds in order to save jobs. It is very easy for employers to hide behind nebulous standards of "fiduciary duty" to deny willing employees their right to band together to salvage their source of income. Standards can be established and procedures administered by the Department of Labor to ensure that nonparticipating employees, those who wouldn't want to do this, would not be penalized.

Congress should consider Pennsylvania's Employee Ownership Assistance Act as a guide for policy. This program provides up to $1.5 million in grants if a group of employees buys an employer in order to save jobs.

The Sacred Heart tragedy is only the tip of the iceberg in the battle over health care reform. Unless we take action, thousands of citizens of this country can expect to suffer the misfortune to which the Sacred Heart employees and Norristown-area community are now doomed.

Thank you for allowing me to testify.

Mr. WAXMAN. Thank you very much, Mr. Koresko.

I appreciate some of those very specific suggestions for us for future legislation. You have been working with these former employees of Sacred Heart.

What kind of assistance have they been receiving to get reemployed? Have there been any organized efforts to provide counseling and job placement services, and based on your knowledge of this community, do you think it is likely that most of these displaced workers will be able to work in this area?

Mr. KORESKO. First of all, I have to say that the hospital made some efforts in organizing a transition committee and they should be given credit where credit is due. There was a local job fair organized with the help of the local Chamber of Commerce and the Joint Hospital Council and I believe that gave people a lot of opportunities. Montgomery Hospital absorbed some of the employees, although I wouldn't call it a significant percentage of the employees. There were some meetings held, I believe, at St. Paul's Church for Catholic social services which tried to help people find jobs.

In general—and I believe also there was a meeting held here that Congresswoman Margolies-Mezvinsky was involved with that also attempted to aid the transition. In short, these situations and all of the hands that go out in these situations don't very oftentimes amount to a lot.

Although the good faith and the effort and the goodwill is there, it doesn't help a lot of people. I think one of the reasons is that Sacred Heart—my wife is in health care. She has been a nurse for over 11 years and works at Montgomery, so it is kind of interesting that I am involved in the Sacred Heart situation at all.

But there is almost a prejudice in the marketplace against LPN's. I know that for a fact that the LPN's would not be hired necessarily at Montgomery of a standard there that they don't hire LPN's as opposed to RN's. Sacred Heart was one of the last places where there was a significant concentration of LPN's.

People that have 20 years of experience can be the greatest nurse in the world, and because they don't have a couple of letters after their name they might not get absorbed into the marketplace. This is something that I don't know whether we can address it from a legislative point of view, but basically experience, in my mind, is a heck of a lot more important than letters on a resume or degrees.

Mr. WAXMAN. What about the health insurance status of these employees? We heard from several people this morning, one of whom lost her insurance, the other two had insurance coverage through spouses; but what is your understanding of what the situation is for the others?

Mr. KORESKO. I have to understand there were basically two programs of insurance with Sacred Heart employees; one was a self-funded program, which is actually another kind of ERISA plan. It is called the Health and Welfare plan. And then there was a fully

insured program through the local HMO's like U.S. Healthcare, and I believe Keystone was involved. The people that were involved in the HMO's under COBRA—COBRA would provide that they get offered replacement coverage, and I believe that even though there was no continuing employer the HMO's voluntarily permitted them to come in but they had to pay the bill.

You are looking at over $450 a month for family coverage from my own experience covering my own employees. Even a single person is going to pay around $200 a month for minimal coverage. The self-funded plan is a different story and the facts are very nebulous at this point.

However, it became clear to me that Metropolitan Insurance Company, the administrator for the plan, which doesn't have direct responsibility as an indemnity insurer, stopped processing claims around the time that the hospital closed even before procedures incurred in May and towards the end of May. This seemed to me somewhat disingenuous with respect to what was told to employees about a week before, that they should be covered towards the end of May. There is no question that the dental plan has been cancelled retroactively to February 28 and I know of a few instances where people have incurred some very serious medical problems shortly after the Sacred Heart closure that have resulted in questionable situations regarding payment; that is, if they are not going to get covered by the Metropolitan plan, it is highly unlikely they will be covered at all.

So it is a tragic—a very, very serious situation. You heard testimony that people might be collecting $250, $350 a week. Now you are talking about having to expend almost 30 percent of their unemployment income to get continuing health care coverage.

In this area, the minimum rent for an apartment is maybe $450, $500 a month. Imagine if you have a mortgage. Unemployment money gets eaten up very quickly. There is basically nothing left, and people have to choose whether they can continue to live and meet day-to-day sustenance requirements or whether they buy health insurance. Most people roll the dice, and that is part of what we are trying to deal with today.

Mr. WAXMAN. That is certainly on our minds in Washington as we look at health care reform. I think we have to have universal coverage because people have to have the security of knowing that they have health insurance that will be there.

Thank you.

Ms. Margolies-Mezvinsky?

Ms. MARGOLIES-MEZVINSKY. How would you respond to the information revealed today that a hospital had the chance to accept a $700,000 loan to bring about what would have amounted to the orderly closure of the hospital?

Mr. KORESKO. I think what you are asking me to do is possibly second guess the decision of the attorneys, who probably gave good advice. If I were in their shoes, knowing what I know about Federal bankruptcy law as opposed to State receivership, I don't think that their advice was at all improper from that limited perspective.

You can't say that what they did was wrong from a management point of view. Management's goal was to do what they needed to do with respect to creditors. Yes, it was an option. State court re-

ceivership is always an option. In most cases, Federal bankruptcy for a debtor of this type is a better situation.

I think that MBIA's presentation stated it best. Management would have been changed in a State court receivership as opposed to Federal bankruptcy under Chapter 11 where the debtor in possession remains in management by definition. So perhaps there are issues there where people don't want to go with a control, which impacted decisions.

Again, Congress passed the Federal Bankruptcy Act and Congress had made decisions about orderly liquidations of assets. Perhaps it is an issue to be raised in conjunction with Federal bankruptcy legislation and take it up there.

Ms. MARGOLIES-MEZVINSKY. I guess my question is more what about the employees? You are the one who has been dealing with them most closely. You are really seeing the effect on their lives.

At what point do we say, this has been a family for all of these years; we have to make sure that the employees are taken care of?

Mr. KORESKO. If there had been compliance with the WARN Act, that is the 60 days notice requirement of closure, perhaps this hearing would not have the same import that it has today.

We wouldn't be talking about people getting 24 hours notice and being thrown out on the street without health care. People could have had orderly transitions and I believe that is what Congress intended when the WARN Act was enacted. Unfortunately without criminal sanctions and without holding individuals accountable that legislation has no teeth.

People hide behind the corporate veil and say, "The corporation did it; I had nothing to do with it." That was raised in a case in the district of Louisiana where a group of employees filed a class action seeking to hold the individuals those officers and directors liable, but they found that the Federal district court agreed with the legislation as written.

You can't get to the individuals. If you can't get to the individuals, then the legislation will always have sort of a toothless effect. That is quite in contrast to what we saw in connection with the Federal payroll taxes.

When you don't pay payroll taxes the individuals at the top, those control persons, are individually liable. So you saw what got paid very quickly before the hospital closed down; those Federal payroll taxes. Why? Because the officers and perhaps directors would have been personally liable for close to $700,000 or $800,000 in moneys owed. If you put the same teeth in the Federal payroll tax laws into the WARN Act this doesn't happen.

Ms. MARGOLIES-MEZVINSKY. Let me continue along those lines. You touched on a little bit in your testimony about the taxes being withheld but not paid. What do you think about the hospitals paying the IRS the $2 million from Medicare?

Mr. KORESKO. From a purely management perspective, if I were the hospital counsel I would have told them make sure you pay the payroll taxes because otherwise you officers who hired me are going to be liable. As a strategy, it may have moral implications to it but the legal implications are the payroll taxes got paid.

Is it right for the United States Government out of its Medicare moneys in essence to go from one pot to another of the United States Government? Perhaps that ought to be examined.

Should there be restrictions on the way that Medicare moneys can be applied and not for payroll taxes? Maybe that is something to look at.

There might be moral import to what we are talking about. Legally what they did was perfectly legal. They cleared up their liability. They had a liability, and the only way they could do it was to use that money.

The unfortunate part about it is that if I were working for somebody and somebody were going to pay me $1,000 or that I had a job and said I get a $1,000 a week and on my W-2 at the end of the year, I got $52,000 on my W-2.

I expect that the employer was ready, willing and able to pay me that $52,000 and the net pay was no more than me giving them money to put somewhere else. That is not the case here. That money was never available. In essence, it sort of deceives an employee.

If they had told me as an employee, "Oh, by the way, we don't have your gross pay. We only have your net pay and we are not going to be able to send your payroll taxes this week", I would have started looking for a job, because if you can't meet your gross payroll, it is an indication that something is wrong, that somebody is in trouble.

That is why my second suggestion was to put into the law mandatory notice that if you can't meet your Federal withholding requirements, that employees be told.

Would it have impacted the level of care? Perhaps, because there might have been a mass exodus or at least employees would have had a chance to find another job.

However, I think that you can't isolate those issues. You have to look at them as a whole and say, "If you are not meeting your payroll taxes, it is time to do something to wind down the hospital."

You can't hide behind expectation of loans in the future and other things that might not ever come to fruition. If you are not meeting your debts in the ordinary course of business and you go to a lender—I can't get a loan if I am not doing that. If I am not paying my bill—one of the ladies today said if she doesn't pay her bills, she is probably not going to be able to get a mortgage in the future.

Yet, that is what happened according to MBIA's testimony. They asked for a loan and not meeting their Federal payroll taxes. How do they expect to get that loan?

It is not reasonable at least in my view to expect that somebody is going to give me money when I am already $700,000 in the hole on Federal taxes and another $500,000 in the hole on a missed bond payment. It just wasn't going to happen.

Good intentions—I don't think anybody in the world would say that management was out to get the employees. I am not here to even imply that because people do what they think is best under the circumstances.

Unfortunately, good intentions don't necessarily add up to good effects. What I am saying here is that Federal legislation in its re-

medial capacity is to prevent situations for people having to use their judgment in such circumstances. If the situation is thus, they ought to know that they are going to be held accountable, but management couldn't be held accountable here; they could hide behind the Federal statute and basically go into bankruptcy. The individuals aren't liable in the bankruptcy, only the hospital is and thus we have the dilemma that exists.

Ms. MARGOLIES-MEZVINSKY. This is a moral question, and I think that you have defined it nicely, and your question really was, I think, they are doing what was, what they thought was right from whose perspective.

Could you just sum up for us what you think, after having dealt with a lot of the employees, went wrong?

Mr. KORESKO. My personal thoughts on this matter are somewhat clouded by a lot of years of experience. I was around in 1976 when Allenwood Steel Company shut down and 2,500 dedicated people got put out of work, including my dad. I saw the same thing here.

People were dedicated, and in health care, the dedication is even more pronounced because of what you have to deal with on a daily basis. What was right—far be it from me to sit in judgment, but I have to say to you that I think that the morale of Sacred Heart was evidenced by the hands-around-the-hospital demonstration that occurred the day after the closure.

I think that in light of such a morale that people deserved a lot better. I think that they gave it their all right up to the end, knowing that perhaps a merger was eminent and the things—that they needed to put out the 110 percent in order to make the merger happen.

What I experienced is betrayal. It is almost as bad as a spouse betraying another spouse. That is how bad it was.

Many people said, "I gave my life to this hospital and I got nothing in return, except I got unemployed, laid off with 24 hours notice. I've got no insurance and now I've got a situation."

What was right is what the law pronounces. The law says give 60 days notice. That is what is right. In this case, what was right and what Congress says is right was not done, and it was intentionally not done.

The intentions flow from business perspectives and there is that age-old question, what happens when companies shut down? Should the business perspective prevail or should the moral perspective prevail?

This hospital functioned under an exception under 501(c) of the IRS Code, which means that we didn't take any taxes from this hospital. It paid no property taxes as an exempt organization.

The community gave something to this hospital and the community in the form of the population of its employees deserved something in return, I believe, and that at least is compliance with the WARN Act and a 60-day notice. That was morally the correct thing to do.

Sacred Heart was an institution that was founded on principles of morality, and I don't believe that is what happened here.

Mr. WAXMAN. Thank you very much, Mr. Koresko, for your testimony.

Our final witness today is J. Russell Walsh, president and chief executive of Sacred Heart Hospital.

Mr. Walsh, we appreciate your participation in this hearing and look forward to your perspectives on what happened at Sacred Heart Hospital. Your prepared statement will be in the record in full. We would like to urge you to stay within 5 minutes in your presentation.

STATEMENT OF J. RUSSELL WALSH, PRESIDENT, SACRED HEART HOSPITAL

Mr. WALSH. This statement is probably about 12 minutes. I think it might be helpful, with your indulgence.

Thank you very much.

Chairman Waxman, Representative Margolies-Mezvinsky, members of the Norristown community, my name is Russell Walsh and I am here on behalf of Sacred Heart Hospital before these proceedings and respectfully submit the following testimony.

Sacred Heart Hospital was founded in 1936 by the Missionary Sisters of the Most Sacred Heart of Jesus. It is licensed for 272 beds and was one of 3 non-profit acute care community hospitals located in the immediate Norristown area. The Sisters came to Norristown committed to serving the health care needs of the community. This had been their mission and it was fulfilled for 58 years until the hospital closed on May 18, 1994.

I do continue with basic information as to the industry and I will dispense with that. I think it has been well covered as to many of the circumstances that do exist.

With three hospitals in one community, however, the impact of the supply and demand factors was obviously exacerbated. Other critical factors were also very much involved.

In this environment the issue was not if one of the Norristown hospitals would fall victim, but when it would occur in light of the excess resources, high debt loads and highly competitive environment impacting to varying degrees on all three institutions.

Relating specifically to Sacred Heart Hospital in the fiscal year ending June 30, 1986, the hospital admitted some 8,459 inpatients. By 1993, this figure was some 6,600 admissions. The hospital experienced operating losses each year commencing in 1989 and was confronted with a very weak cash position with no reserves or foundation moneys.

Summary financial data from the hospital audited statements from 1986 forward are included in the complete text.

Although revenues were increasing during this period, expenses were increasing at a higher rate. Despite cost containment efforts, this trend continued and what little cash the hospital did have continued to be depleted.

I assumed the presidency of Sacred Heart Hospital in October 1992. Because of the hospital's recent history of losses, significant internal efforts were undertaken to achieve cost savings and reduce expenses to correspond to reduced volumes and revenues.

The hospital-wide cost-containment program which was instituted included significant reductions in force, an early retirement program, renegotiated contracts with physicians and resulted in the reduction in expenses for the fiscal year ending June 30, 1993

and real budget reductions of some $6 million for the fiscal year ended June 30, 1994.

As of March 31, actual expenses were under this budget for the 9 month period. The necessary and difficult decisions to achieve these results created uncertainty in the Norristown community as to the viability of the hospital and we believe resulted in further deterioration of patient volumes.

It was recognized by the community leadership that steps needed to be taken to coordinate health resources to meet Norristown's immediate needs. An effort was initiated to bring the three hospitals together to pursue a community solution to stabilize the environment and reduce the unnecessary duplication of services.

To address these concerns, in April 1993 the Norristown hospitals approved the creation of a joint venture study committee. A consultant was retained to perform a study and the conclusion reached was that Norristown's health care delivery system was indeed fragile and that a new consolidated single entity with less than three acute care campuses would be necessary to achieve the economies of scale and properly deal with the many changes occurring in health care.

This report was rendered in October 1993, endorsed by the boards of the three hospitals, and steps were immediately taken to develop a letter of intent.

Communications were critical in this consolidation effort. Numerous meetings were held with many constituencies associated with the hospital, and although the need for the consolidation and its long-term benefits were recognized by many, the prospect of change was also very difficult for many to accept.

By February of 1994, the efforts to achieve a consolidation were proceeding in accordance with the established time frame. Sacred Heart recognized that it would need access to additional financial resources to sustain it through the contemplated consolidation. Because of these circumstances the hospital approached the insurer of its tax exempt bonds for bridge financing in March 1994.

This organization, MBIA, had been advised by the hospital of our financial status initially in August 1993 and they had continued to monitor the hospital on an ongoing basis. MBIA agreed to consider such a loan subject to an analysis by an independent consultant. The consultant was engaged by MBIA and initiated its review of the hospital on March 29th.

In an April 19th letter, MBIA indicated its willingness to continue its consideration of an operating loan provided certain conditions were met by the hospital. Steps were taken to meet these conditions.

Meanwhile, the consolidation efforts were proceeding although Suburban General Hospital withdrew from these efforts in March 1994 due to the unexpected illness of its president. Sacred Heart and Montgomery hospital proceeded with a vote by their board of directors to endorse the letter of intent to consolidate the three hospitals and create a new single entity and also endorsed a two-hospital letter of intent based upon the same principles in the event that Suburban General could not proceed with the process in a reasonable time frame, and with the concurrence of Suburban Gen-

eral, Sacred Heart and Montgomery accelerated the consolidation process based upon the two-hospital letter of intent.

On May 5 and 6, there were a total of 6 open employee meetings at Sacred Heart hospital which were attended by a total 300 employees. At each of these meetings, which lasted approximately 1 hour and 15 minutes, I provided a report on the MBIA loan status and its import, the billing situation and its impact on the hospital, the status of the accelerated consolidation possess, and the very tenuous financial conditions under which we were operating. A question-and-answer period was part of these meetings.

Sacred Heart and MBIA met to review the legal documents to accomplish the loan on Sunday, May 8 and it was expected that the loan would close during the following week. However, on May 10, MBIA advised the hospital officials that it was no longer prepared to proceed with the loan arrangements.

At this point, the hospital had a payroll due to be paid on May 13. Our immediate focus of necessity was to obtain cash to meet the upcoming payroll.

On May 9, the hospital had initiated an application process through its Medicare intermediary to request an advance from Medicare against processing of approximately $3 million in claims for services already provided to patients.

This advance had been projected to be required in addition to the MBIA loan for continued operations. Because this advance was not expected until May 16th or 17th, steps had to be taken to meet the payroll. We contacted U.S. Healthcare and were granted an advance which allowed the payroll to be met on May 13th.

Subsequent to the May 10, 1994 decision of MBIA to deny the loan, MBIA's representatives met with officials of Montgomery Hospital whose bonds are also insured by MBIA and agreed to review a revised plan of consolidation which would be in the form of an asset acquisition.

The Executive Committee of Sacred Heart Hospital's medical staff and their department heads were apprised of that in the meetings held on May 11. Representatives of both hospitals spent May 12 through May 16 developing a revised plan with financial projections for presentation to MBIA. The goal was still one of achieving a consolidation.

Because of the critical financial situation and because moneys for continued operations were not assured, the administrative staff in consultation with key personnel developed a contingency plan for the orderly transfer of patients should it become necessary to discontinue services. Additionally, the other two community hospitals were notified in order to commence plans at their facilities should it become necessary for reasons of ongoing quality care to transfer patients.

We also contacted Montgomery County Emergency Medical Services to determine its capabilities to transfer patients via ambulance. During the week of May 14 and 15, it became evident without additional financing that the lack of sufficient cash to ensure continuing care to patient and payment of employees for time worked indicated that the hospital would only be able to remain open for several days and not the weeks that would be required to conclude a sale or merger.

The hospital's priority had always been and continued to be the welfare of patients. A closure plan was reviewed with representatives of the State Department of Health, who concurred with our plan should it need to be implemented.

On May 17, we received an advance from Medicare in the amount of $2,012,000. These funds were used to pay employees through May 18, 1994, resolve tax obligations owed to the IRS and Pennsylvania and to the extent possible to extend employee benefits through May 31, 1994.

On Tuesday, May 17, an additional effort was made in a meeting with MBIA to obtain working capital, after which a decision was made to close the hospital and implement the transfer plan. Employees, medical staff and patients in the community were notified and the transfer of patients was accomplished in accordance with the plan on May 18th.

The decision to close Sacred Heart was not made prior to May 17th because ongoing negotiations were taking place to allow the hospital to remain open through a consolidation. Hospital employees were paid the full amount of their wages on the following Monday. After several days for the employees to cash their checks, the hospital did file for bankruptcy on May 25.

By way of summary, the recent history of Sacred Heart is clearly one of a troubled institution in a community with excess resources in a financially troubled industry. Ironically, the closing of Sacred Heart should in the long term enable a more financially stable health care delivery system that can respond to meet the needs of our community.

Unfortunately, this closing will not be unique to Sacred Heart or to Norristown, Pa, but is a by-product of a market in transition facing a tremendous degree of uncertainty.

Although the closure has been considered abrupt by many the signs of serious community problems in Norristown's health care infrastructure had been the subject of discussion for years. The decision was made to close only after all reasonable efforts to sustain the hospital to a consolidation had failed.

The decision to close and the process of closing were based upon the best interests of the patients. An extended period of time between the announcement of closure and closure would not have been conducive to ongoing quality care and without the assurance of adequate funds for proper supplies and the prospect of staff not being compensated for time worked, patients may have been put in jeopardy, and this could not be permitted. Thus, the plan to transfer patients in a 1 day time period, which due to the efforts of many went extremely well, was in the best interest of patients when considering the circumstances.

In human terms, the closing of Sacred Heart on May 18th was indeed a tragic situation which has affected many. The Missionary Sisters of the Most Sacred Heart of Jesus, the board of directors and the Sacred Heart family of employees and others affiliated with the hospital through the years have a long record of providing quality care and community service.

Many positive efforts had been made by the dedicated people of Sacred Heart to allow the hospital to participate in an orderly restructuring of health care resources in Norristown but to no avail.

In this public forum, I would be remiss if I did not acknowledge and extend my sincerest thanks to those who were indeed Sacred Heart. I would like to express my particular thanks to the Sisters and the board of directors for their many hours of effort on behalf of the hospital and the community during the 19 months I served as president of Sacred Heart prior to its closing, as well as their continuing support.

Thank you Mr. Chairman and Congresswoman.

Mr. WAXMAN. Thank you very much, Mr. Walsh.

[The prepared statement of Mr. Walsh follows:]

July 11, 1994

Statement by
Sacred Heart Hospital of Norristown
for Submission to the
Subcommittee on Health and the Environment
of the
Committee on Energy and Commerce
of the
United States House of Representatives
in conjunction with the testimony of
J. Russell Walsh, President

Sacred Heart Hospital was founded in 1936 by the Missionary Sisters of the Most Sacred Heart of Jesus, is licensed for 272 beds and was one of three non-profit acute care community hospitals located in the immediate Norristown area. The Sisters came to Norristown committed to serving the health care needs of the community. This had been their mission and it was fulfilled for fifty-eight years until the Hospital closed on May 18, 1994. One of the other two hospitals, Montgomery Hospital, is one block away and has a comparable licensed bed capacity, while the second, Suburban General Hospital, is approximately one mile north of Sacred Heart with a licensed bed capacity of approximately 150 beds. The primary service area population served by Sacred Heart was essentially a common service area served by all three institutions. Additionally, there are seven other acute care hospitals within a ten-mile radius of Norristown and a total of twenty-nine other acute care hospitals within a ten to fifteen mile radius of Norristown.

In 1983, the admission/discharge rate per 1,000 population of the primary service area was 137.5 resulting in some 35,510 inpatient discharges. By 1992, this rate had dropped to 93.6 or 27,855 inpatient discharges, a decrease of 22%. During this same period, the percentage of patients in the primary service area who needed hospitalization and used one of the three Norristown hospitals decreased as more of these patients chose to use hospitals outside Norristown.

This brief utilization summary demonstrates one of the key circumstances underlying the market conditions which existed in our community and affected Sacred Heart Hospital. These factors and trends are not unique to this community and similar circumstances exist to varying degrees across the country. With three hospitals in one community, however, the impact of these supply and demand factors is obviously exacerbated. Other critical factors that have decreased the demand for acute care services include: significant technological advances, restrictions on reimbursement, the emerging dominance of managed care, increased competition from non-traditional providers and industry changes and adjustments occurring in anticipation of national health care reform. Thus, no one factor, but a combination of multiple market factors have converged to adversely impact on the local market area and Sacred Heart Hospital over a period of years. In this environment, the issue was not if one of the Norristown hospitals would fall victim, but when it would occur in light of the excess resources, high debt loads and highly competitive environment impacting to varying degrees on all three institutions.

Relating specifically to Sacred Heart Hospital, in the fiscal year ending June 30, 1986 the Hospital admitted 8,459 inpatients. For the year ended June 30, 1988 this figure was 7,537 admissions and for the year ended June 30, 1989 the figure was 6,946 admissions. For the next three years, the admissions remained essentially constant as follows:

Fiscal Year Ended June 30, 1990	7,017 admissions
Fiscal Year Ended June 30, 1991	7,015 admissions
Fiscal Year Ended June 30, 1992	7,150 admissions

At this same time Sacred Heart Hospital was experiencing continuing volume decreases, it experienced operating losses and was confronted with a very weak cash position, with no reserves or foundation monies.

Summary financial data from the Hospital's audited statements are as follows:

	FY 6/30/86	FY 6/30/87	FY 6/30/88	FY 6/30/89	FY 6/30/90	FY 6/30/91	FY 6/30/92
Net Patient Service Revenues	38,602,403	39,835,515	41,791,802	43,351,148	44,486,234	49,468,268	52,353,053
Other Operating Revenues	977,071	955,389	825,961	1,031,566	1,452,768	1,515,987	1,497,799
Operating Expenses	37,794,361	40,199,600	41,932,709	45,181,861	46,565,247	51,321,660	55,459,146
Net Operating Gain (Loss)	2,610,105	1,465,576	685,054	(799,147)	(626,245)	(337,405)	(1,608,294)

Although revenues were increasing during this period, expenses were increasing at a higher rate. Despite cost containment efforts, this trend continued and, what little cash the Hospital did have, continued to be depleted.

Recognition of these trends during this period and the competitive environment for diminishing patient volumes presented the need to address the issues and excess capacity that existed in Norristown. Although, during the past decade, several formal efforts were initiated among the three Norristown area hospitals to accomplish activities and develop services on a cooperative basis to serve the community, these activities unfortunately met very limited success. In 1989, the Norristown Regional Cancer Center was developed as a joint venture between affiliates of Sacred Heart Hospital and Suburban General Hospital. Also, Suburban General Hospital was a co-sponsor of a cardiac catherization service located at Sacred Heart. These cooperative programs between the two institutions resulted in additional joint efforts and the creation of a new corporation, Norristown Regional Health Services, in October 1992 with the express purpose of pursuing additional joint planning to serve the community and achieve cost savings.

I assumed the presidency of Sacred Heart Hospital in October 1992. Because of the Hospital's recent history of losses, significant internal efforts at Sacred Heart were undertaken to achieve cost savings and reduce expenses to correspond to reduced volumes and revenues. An early retirement program was implemented, numerous physician contracts were renegotiated with

reductions in payments for administrative services as well as the length of the terms of the contracts. Adjustments were also made in the mechanism to compensate physicians for professional services. A significant reduction in force occurred in January 1993; a subsequent reduction occurred in August 1993 because of continuing reductions in volume and revenue. Ongoing efforts were also made by management to reorganize Hospital operations at all levels, adjust and enhance Hospital systems and procedures to both insure quality care and achieve more cost effective operations. This hospital-wide cost reduction program resulted in a reduction in expenses for the fiscal year ending June 30, 1993 and real budget reductions of some $6,000,000 for the fiscal year ended June 30, 1994. As of March 31, 1994, actual expenses were under this reduced budget for the nine month period. The necessary and difficult decisions to achieve these results created uncertainty in the Norristown community as to the viability of the Hospital and, we believe, resulted in further deterioration in patient volumes.

During the period leading up to the Spring of 1993, all of the hospitals in the community continued to be impacted by the multiple forces affecting health care at the national, regional and local levels. It was recognized by the community leadership that steps needed to be taken to coordinate health resources to meet Norristown's immediate needs and be well-positioned to integrate our collective resources with other health care providers and insurers as the region's health care delivery system evolved. An effort was initiated to bring the three hospitals together to pursue a community solution to stabilize the environment, reduce the unnecessary duplication of services and achieve a financially sound local health care delivery system. To address these concerns, in April 1993, the Norristown hospitals approved the creation of the Joint Venture Study Committee. The Committee was comprised of representatives of the boards and administrations of each hospital; its objective was to accomplish a study which documented the tangible benefits, if any, of various levels of cooperation. Legal counsel was retained to guide the group in anti-trust areas and an initial meeting was held in early May 1993. A physician representative from each hospital was also subsequently added to the Committee. A consultant was retained to perform the study and the conclusion reached was that the Norristown health care delivery system was indeed fragile and that a new consolidated single entity with less than three acute care campuses would be necessary to achieve the economies of scale and properly deal with the many changes occurring in health care. This report was rendered in October 1993, endorsed by the boards of the three hospitals, and steps were immediately taken to develop a Letter of Intent among the hospitals.

Communications were critical in the consolidation effort. Numerous meetings were held with the various constituencies of Sacred Heart Hospital to include the medical staff, employees, auxiliaries and volunteers. As the process proceeded, updates were provided with respect to the proposed nature of the relationship, the need for these steps and changes and their anticipated impact. Although the need for the consolidation and its long-term benefits were recognized by many, the prospect of change was also very difficult for many to accept.

As the Joint Venture Study Committee process proceeded, the financial position of Sacred Heart continued to deteriorate despite the cost savings achieved and efforts to increase volumes within the constraints of the minimal resources available. In November 1993, after ongoing efforts to improve the collection of receivables due the Hospital for services rendered to patients, a decision was made to out-source the collection of accounts receivable and finance certain of these accounts to obtain an immediate cash infusion and a funding base to support Hospital operations.

Related to the changeover to the outside billing company was an upgrade to a new billing format required by Medicare. Computer software problems were encountered in this changeover, which further delayed the ability of the Hospital and the billing company to submit bills in a timely fashion. These problems further strained the Hospital's already fragile financial situation.

By February 1994, the efforts to achieve a consolidation were proceeding in accordance with the established timeframe. Sacred Heart Hospital recognized that it would need access to additional financial resources to sustain it through the contemplated consolidation. Because of these circumstances, the Hospital approached the insurer of its tax-exempt bonds for bridge financing in March 1994. This organization, Municipal Bond Investors Assurance Corporation (MBIA), had been advised by the Hospital of our financial status initially in August 1993, and had continued to monitor the Hospital on an ongoing basis. MBIA agreed to consider such a loan, subject to an analysis by an independent consultant. The consultant engaged by MBIA initiated its review of the Hospital on March 29, 1994. In an April 19, 1994 letter, MBIA indicated its willingness to continue its consideration of an operating loan, provided certain conditions were met by the Hospital. Steps were taken to meet these conditions.

Meanwhile, the consolidation efforts were proceeding although Suburban General Hospital withdrew from these efforts in March 1994 due to the unexpected illness of its President. Sacred Heart and Montgomery Hospital proceeded with a vote by their respective Boards of Directors to endorse the Letter of Intent to consolidate the three hospitals and create a new single entity, and also endorsed a two-hospital Letter of Intent based upon the same principles in the event that Suburban General was not able to proceed with the process in a reasonable time period.

Because of Sacred Heart Hospital's financial status, and with the concurrence of Suburban General Hospital, Sacred Heart and Montgomery Hospital accelerated the consolidation process based upon the two-hospital Letter of Intent. We jointly commenced the legal and financial due diligence process and continued to work toward a definitive agreement. Options were also considered by which Montgomery Hospital might be able to assist Sacred Heart in sustaining itself to achieve a consolidation.

On May 5 and 6, 1994, there were a total of six open employee meetings at Sacred Heart which were attended by a total of some three hundred employees. At each of these meetings, which lasted approximately one hour and fifteen minutes, I provided a report on the MBIA loan status, the billing situation and its impact on the Hospital, the status of the accelerated consolidation process and the very tenuous financial conditions under which we were operating. A question and answer session was part of each of these meetings.

Sacred Heart Hospital and MBIA met to review the legal documents to accomplish the loan on Sunday, May 8, 1994, and it was expected that the loan would close during the following week. However, on May 10, 1994, MBIA advised the Hospital officials that it was no longer prepared to proceed with the loan arrangements. At this point, the Hospital had a payroll due to be paid on May 13, 1994; our immediate focus, of necessity, was to obtain cash to meet the upcoming payroll.

On May 9, 1994, the Hospital had initiated an application process through its Medicare intermediary to request an advance from Medicare against processing of approximately $3 million in claims for services already provided to patients. This advance had been projected to be required in addition to the MBIA loan for continued operations. Because this advance was not expected until May 16 or 17, 1994, steps had to be taken to meet the payroll. We contacted U.S. Healthcare and were granted an advance which allowed the payroll to be met on May 13, 1994.

Subsequent to the May 10, 1994 decision of MBIA to deny the loan, MBIA's representatives met with officials of Montgomery Hospital (whose bonds are also insured by MBIA) and agreed to review a revised plan of consolidation which would be in the form of an asset acquisition. The Executive Committee of the Sacred Heart Medical Staff and Department Heads were apprised of the circumstances in meetings held on May 11, 1994. Representatives of both hospitals spent May 12 through 16, 1994 developing a revised plan with financial projections for presentation to MBIA. The goal was still one of achieving a consolidation.

Because of the critical financial situation and because monies for continued operations were not assured, the administrative staff, in consultation with key personnel, developed a contingency plan for the orderly transfer of patients should it become necessary to discontinue services. Additionally, the other two community hospitals were notified in order to commence plans at their facilities should it become necessary for reasons of ongoing quality care to transfer patients. We also contacted the Montgomery County Emergency Medical Services director to determine its capabilities to transfer patients via ambulance.

During the weekend of May 14-15, 1994, it became evident, without additional financing, that the lack of sufficient cash to insure continuing care to patients and payment of employees for time worked indicated that the Hospital would only be able to remain open for several days, and not the weeks, that would be required to conclude a sale or merger with Montgomery Hospital. The Hospital's priority had always been and continued to be the welfare of patients. A closure plan was reviewed with representatives of the State Department of Health who concurred with our plan should it need to be implemented. On May 17, 1994, we received an advance from Medicare in the amount of $2,012,000. These funds were used to pay employees through May 18, 1994, resolve outstanding payroll tax obligations owed to the IRS and Pennsylvania and, to the extent possible, to extend employee benefits through May 31, 1994.

On Tuesday, May 17, 1994, an additional effort was made in a meeting with MBIA to obtain working capital, after which a decision was made to close the Hospital and implement the transfer plan. Employees, medical staff, patients and the community were notified and a transfer of patients was accomplished in accordance with the plan on May 18, 1994.

The decision to close Sacred Heart Hospital was not made prior to May 17, 1994 because ongoing negotiations were taking place to allow the Hospital to remain open through a consolidation. Hospital employees were paid the full amount of their wages through May 18, 1994 on the following Monday, the earliest day the checks could be calculated and delivered by the Hospital's payroll firm. Arrangements had been made at five branches of the Hospital's bank for employees to cash their checks. After allowing several days for employees to cash their checks, the Hospital filed for bankruptcy on May 25, 1994.

* * * * * * *

By way of summary, the recent history of Sacred Heart Hospital is clearly one of a financially troubled institution in a community with excess resources in a financially troubled industry. Ironically, the closing of Sacred Heart should, in the long term, enable a more financially stable health care delivery system that can respond to meet the needs of our community. Unfortunately, this closing will not be unique to Sacred Heart or Norristown, Pennsylvania, but is a byproduct of a market in transition facing a tremendous degree of uncertainty.

Although the closure has been considered abrupt by many, the signs of serious community problems in Norristown's health care infrastructure had been the the subject of discussion for years. The decision was made to close only after all reasonable efforts to sustain the Hospital to a consolidation had failed. The decision to close and the process of closing were based upon the best interests of the patient. An extended period of time between the announcement of closure and closure would not have been conducive to ongoing quality care and, without assurance of adequate funds for proper supplies and the prospect of staff not being compensated for the time worked, patients may have been put in jeopardy and this could not be permitted. Thus, the plan to transfer patients in a one day time period which, due to the efforts of many, went extremely well was in the best interests of patients when considering the circumstances.

In human terms, the closing of Sacred Heart Hospital on May 18, 1994 was a tragic situation which has affected many. The Missionary Sisters of the Most Sacred Heart of Jesus, the Board of Directors, the Sacred Heart family of employees and others affiliated with the Hospital through the years have a long record of providing quality care and service to the community. Many positive efforts had been made by the dedicated people of Sacred Heart to allow the Hospital to participate in the orderly restructuring of health care resources in Norristown, but to no avail.

In this public forum, I would be remiss if I did not acknowledge and extend my sincerest thanks to those who were, indeed, Sacred Heart Hospital. I would also like to express my particular thanks to the Sisters and the Board of Directors for their many hours of effort on behalf of the Hospital and the community during the nineteen months I served as president of Sacred Heart Hospital prior to its closing as well as their continuing support.

Mr. WAXMAN. I recognize that this has been a difficult time for you and that the closure of the institution you led is not the outcome you desired. Nevertheless, the hospital has closed and its employees and the community at large have suffered a great loss.

I think it would be helpful for you to tell us what you have learned from this experience and what things could be done to make this outcome less devastating for those associated with this hospital, and in your opinion, how much of the difficulties of Sacred Heart can be attributed to the changing market for hospital services?

Mr. WALSH. I think, Mr. Chairman, that there were many factors that had come into play over an extended period of time that affected Sacred Heart and perhaps more particularly the Norristown community where there certainly was an excess of resources and in the period of time when the hospital industry was in a very competitive mode, yes, there were three institutions that competed to take care of patients, to be full-service hospitals and for much of that period of time they did prosper, if you will, and each in their own way provided very quality care.

As circumstances changed and with those resources, it became extremely difficult to cover all of the obligations, the expectations of patients and that was exacerbated in the statement.

I think, if I might, I would like to use an analogy that I recently read that I think maybe portrays some of the issues facing this country and that I hope in health care reform and in the steps that are going to be taken will be addressed in some way shape or fashion.

If you will allow me one moment. It deals with a man by the side of a river. I told our employees this at those employee meetings. I used the same analogy, I believe, in each of those six meetings.

One day he saw a man drowning coming down the river and he saved him. Next day he saw the same thing. He called his friends and said, "We better get a rope and ladder", and they did. The next day, they saw the same thing. Pretty soon, they built a business around stopping people from drowning and that business prospered. One day one of the people said, "Gee, I wonder why those people are falling in the river", and the partner said "Don't ask that question. We have a nice business here."

Where this industry today is, it is a nice business taking care of sick people. That is the way it has developed. If we move toward capitation or prevention, which I suggest is the appropriate way, that is the way to go to look up river. In so doing, there is a big industry down river that is there, that has a lot of debt, a lot of overhead, and it does need to be addressed in the process or it will become even more difficult going forward.

I would like to suggest to yourself—Mr. Waxman and yourself—that hopefully those considerations as we move forward can be incorporated into legislation. I believe that one key factor that needs to be addressed that may be helpful is some of the antitrust considerations that do exist and are very much an issue.

Mr. WAXMAN. However we resolve these issues of restructuring health care reform, there are going to be dramatic changes and some institutions are not going to survive. What about the workers

of those institutions? Shouldn't they be able to get some notice, ability to have a transition in their lives?

Don't you think that we could do something to make the outcome less devastating for those associated with an institution like Sacred Heart? Shall we write some of that into the law as well?

Mr. WALSH. I believe that would be appropriate to attempt to write into the laws. It is very difficult because we are dealing in our industry with patients. I think it is important to make a distinction that in much of manufacturing if one makes a conscious decision to move a plant for geography or better wage structures, that can be done and may not affect the business.

With the health care industry and patients, I would suggest that at least in Sacred Heart's situation where we were attempting to save jobs and achieve an orderly transition, even though the creation of a new entity would have had an impact on jobs that was part of the necessary purpose, that it is difficult to give significant advance notice because of the potential impact on patients.

That is a very delicate balance, Mr. Chairman. I wish I had a concrete answer. I certainly did not want—and many people worked hard to prevent what did happen at Sacred Heart. Sixty days, ninety days' notice, that may have other implications on how that is balanced in the law. It is a very difficult one.

Mr. WAXMAN. Thank you.

Ms. Margolies-Mezvinsky?

Ms. MARGOLIES-MEZVINSKY. My question to you really is if I were in this audience as an employee—help me out a little. I heard you say, in the end what you said in your testimony was that there was a fear of mass exodus and that the quality of care would have disintegrated had you not waited until the last minute to tell your employees that the hospital was closing. I would be hurt.

Hearing the testimony of the employees here, the one thing that I got from them was that it was a very, very dedicated group and that at the very least, they deserved more than 24 hours. Sixty days would have been wonderful. Thirty days would have been fair, perhaps. But 24 hours was just plain unfair, and I would like you to clarify a little bit what you said there at the end, from your statement, that your fear was that in essence, the bottom would have fallen out of the quality of the care. I think the employees deserve an explanation, if you could give me one.

Mr. WALSH. I will certainly attempt to do so.

I believe in my statement, I outlined the various attempts being made at multiple levels to obtain financing to achieve a consolidation and to avoid the tragic event that did happen. When we got together over the weekend of May 14 and 15th, it became apparent that there would not be sufficient cash available to assure the continuance of supplies and to assure that people, employees, would be paid for the time worked.

In that context, a very difficult decision, one that I know a lot of people absolutely worked very hard not to have to be confronted with, had to be made in the best interests of first the patients, and that was that we would not be able to continue after the 18th and pay employees and meet the necessary obligations to patients.

There was no assurance, and on the evening of the 17th, after a final meeting or a meeting, an additional meeting, I should say,

with MBIA to see if something could be achieved to attain a more orderly transition and it was not able to be achieved, that decision was made.

Ms. MARGOLIES-MEZVINSKY. I guess what we heard from the employees was that there was this continued message of hope that had been given to them with regard to your meetings to them; that is a merger is—we are hoping for a merger—that there wasn't a sense that this 24-hour closing or notification was going to happen?

Mr. WALSH. In the employee meetings on May 5th and 6th, which I believe were very candid and open meetings—maybe not at each of them, but at most—the question was asked by an employee, is there a chance of that, that the hospital will close. The answer I gave was that we are working very concertedly to obtain advance funding, additional funding and to achieve a consolidation, but that cannot be precluded.

I think human nature—and please do not misunderstand this statement, I do it, I think we all do it—human nature tries to grab on to a straw, and that was there, that very human element of denial on the part of many who loved that hospital—I believe that was a factor, yes I do.

I think many of them wanted this to happen and didn't think that the hospital could close.

Ms. MARGOLIES-MEZVINSKY. Can you give any explanation about the delay in payments to the employees' tax-sheltered annuity plan as well as not paying the IRS taxes withheld from the employees' paychecks?

Mr. WALSH. Yes. As I think has been portrayed, Sacred Heart Hospital had had problems with cash and with accounts payable for a period of time, and was trying to deal with those, to manage those and to improve upon those within the confines and availability of resources.

There were decisions that were made that were first devoted to patient care; second to the payment of employees, and taxes were delayed and were not paid.

As was mentioned, there were meetings with and understandings with the IRS in that regard as they relate to taxes and ongoing payments were made, although some were delayed.

With respect to the TSA payments, a similar situation existed in terms of the allocation of the available resources that were coming in on an intermittent and inconsistent basis and decisions had to be made almost daily as to the utilization of that cash. When that came to my attention, we did catch up for a period of time, but then as the circumstances deteriorated, there was a delay in the payment of those moneys.

When the hospital closed, those payments had—were all made and were current. Unfortunately, with respect to one of the TSA's, although the payment had been made, it did not—it was not processed through the bank system at the time the bankruptcy was declared, and that was tied up in the bankruptcy process.

Ms. MARGOLIES-MEZVINSKY. Was there ever any thought or consideration given to what responsibilities the administration and corporate board had in bringing about an orderly closure of the facility, including some kind of reasonable notice of termination to the employees?

Mr. WALSH. The administration, and I believe the board, attempted to be very conscious of the employees and what we were attempting to achieve. The consolidation process was the goal and what had been worked very diligently on by many to achieve an orderly transition—that was the intent, so that there could be plans amongst the three institutions to more orderly downsize the community, and that is where the efforts were focused.

Ms. MARGOLIES-MEZVINSKY. Even though you fell short? Even though, with regard to giving them any notice, you fell short?

Mr. WALSH. Fell short—unfortunately, yes we did.

Ms. MARGOLIES-MEZVINSKY. Could you explain Sacred Heart's decision to use the $2 million of Medicare reimbursement to pay off the IRS rather than to use the money to help complete the closure? On our sheet, it shows that you could have spaced out the payments at $173,000 over a period of time.

Mr. WALSH. If I understand your question, with respect to the arrangement with the IRS——

Ms. MARGOLIES-MEZVINSKY. That is right; the arrangement that you had worked out with the IRS to space out the payments as opposed to giving them a lump sum so that an orderly closure perhaps could have been arranged perhaps giving your employees a little more time to figure out what was going on.

Mr. WALSH. The arrangement with the IRS was one predicated on a continuing institution and entity. When it became apparent that the distinct probability was that would not occur, there were prioritizations of payment and that was concluded by management to be a prioritization to bring that current as opposed to the arrangement which, as I mentioned, would have been intended for an ongoing situation.

Ms. MARGOLIES-MEZVINSKY. During our investigation, my office requested certain documents from Sacred Heart. Among those documents are the minutes of the board meetings for the last 18 months. The documents show a consistent practice of recording notes in the meetings. However, there were no minutes for any meetings held after April 19, 1994.

Could you give us an explanation for this departure from practice?

Mr. WALSH. Yes, I can. They were not prepared at the time of your request because from April 19th on, candidly, the hospital was in a mode very much of survival, and the staff resources were such that those minutes had not yet been prepared.

Ms. MARGOLIES-MEZVINSKY. For the record and for those people whose lives have been affected by this, if I were one of your employees just asking you what the heck happened, why couldn't you have shared this with us—some of these people have been employed by you for years and years and years. "Why in the end were we"—just pretend I am one of your employees—"Why were we treated this way?" What would the answer be?

Mr. WALSH. My answer to that would be that many, many people were focused on achieving that consolidation and sustaining that facility so that this tragic event would not occur. That is what was felt to be in the best interests and that is what we tried to achieve and unfortunately we came up short.

Ms. MARGOLIES-MEZVINSKY. And to the community?

Mr. WALSH. I believe the community will absolutely miss Sacred Heart Hospital. As I said in my statement, as tragic as this situation is, ironically it may allow the community to have a more viable health care delivery system to meet the challenges and ultimately serve the community.

Ms. MARGOLIES-MEZVINSKY. Thank you, Mr. Walsh.

Mr. WALSH. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much. That concludes the testimony that we are to receive at this hearing. I wanted to see if Ms. Margolies-Mezvinsky had any closing statements.

Ms. MARGOLIES-MEZVINSKY. I do.

Thank you for holding this hearing. As you know, my office has been investigating the closure of Sacred Heart Hospital and we appreciate your assistance, Mr. Chairman, and the cooperation that we have had with this investigation.

Through our investigation, we have discovered allegations of fraud and abuse. These allegations go beyond the scope of my office. Therefore, today I spoke with the Office of the Inspector General of the Department of Health and Human Services and I would like to read you the letter that I sent to Ms. June Gibbs Brown.

"Dear Inspector General Gibbs Brown: Please accept this letter as a formal request for an investigation into the operation and closing of Sacred Heart Hospital based in Norristown, Pa.

"As we discussed by phone, my office has conducted an investigation of the events leading up to the closing of the Sacred Heart Hospital. This investigation has uncovered allegations of fraud and abuse on the part of the hospital's administration.

"I am, therefore, directing my staff to turn over all information and documents gathered during this investigation to your office immediately.

"Thank you for your consideration of this request. Please keep my office informed of any developments related to Sacred Heart Hospital.

"Warm regards."

I thank you very much, Mr. Chairman.

Mr. WAXMAN. Thank you.

That concludes our hearing for today and we stand adjourned.

[Whereupon, at 1:40 p.m., the hearing was adjourned.]

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